

Associates in Gynecology- Patient Medical History

Date ____/____/____

Your name: _____ **Age** _____
 G ____ P ____ LMP ____/____/____ Birthdate ____/____/____
 Family physician _____ Who referred you? _____

Reason for today's visit?

Medical History: Please check if you have had any of the following:

Anemia	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>
Anorexia/Bulimia	<input type="checkbox"/>	Fibroid Uterus	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>
Asthma/Lung Disease	<input type="checkbox"/>	Genetic/Inherited Disease	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>
Blood Clot in leg/lung	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Urinary Problem	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	Other	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>		
Depression/Anxiety	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>		

Are your immunizations up to date? Yes No Have you received Gardasil? Yes no
 Have you had a colonoscopy? Yes No Date: _____ Result: _____
 Have you had a bone density scan ? Yes No Date: _____ Result: _____
 Date of last mammogram? ____/____/____ Result _____

Surgical History: list all surgeries you have had. **Allergies**

Type of surgery	Date	Are you allergic to Food ? Yes No <i>List allergy and reaction:</i>
1		_____
2		_____
3		Are you allergic to Medications ? Yes No <i>List allergy and reaction:</i>
4		_____
5		_____

Medications: Please list all medicines, vitamins and herbs you are taking. List dose.

1	5
2	6
3	7
4	8

Family History: Please list relatives with the following medical problems.

Anemia	High Cholesterol
Breast Cancer	Blood clot legs/lungs
Ovarian Cancer	Migraines
Colon Cancer	Mental Illness/Depression
Other Cancer(type)	Stroke
Diabetes	Asthma
Heart Problems	Urinary/Kidney problem
High Blood Pressure	Other:

Social History: Please check and circle all that apply.

Your occupation: _____ Marital Status: S M D How long? _____
 Spouse Name: _____ Spouse Occupation: _____
 Yes no Do you currently or did you smoke? How many packs per day? ____ Year quit ____
 Yes no Do you drink alcohol? If yes, how many drinks per week? _____
 Yes no Do you/have you used drugs(marijuana, cocaine, heroin)? How much? _____
 Yes no Have you ever been the victim of sexual abuse or rape?
 Yes no Do you exercise on a regular basis? If yes,how often?

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Obstetrical History

Please list deliveries:

# of pregnancies? _____ Miscarriages? _____	<i>Delivery date</i>	<i>Vag. or C-sec.</i>	<i>Weight</i>
Terminations? _____	1		
Ectopic (tubal) pregnancies? _____	2		
Adopted Children? _____	3		
Did you have gestational diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	4		
Did you have pre-eclampsia? <input type="checkbox"/> Yes <input type="checkbox"/> No	5		

Gynecological /Sexual History: Please check and circle all that apply to you.

Date of last pap smear? _____ Result: _____

Have you ever had an abnormal pap smear? Yes no **Explain:** _____

Cervical procedures: Colposcopy/cervical biopsy Cryotherapy/Laser of the cervix

Age first menstruation: _____ Average # of flow days _____

Days from start of one period to start of the next _____ Are your periods regular? Yes No

Yes no Do you have bleeding in between your periods?

Yes no Do you have severe cramps? Medications taken?

Yes no Have you had to seek medical attention for excessive bleeding?

Explain: _____

Yes no Are you concerned that your periods are too heavy?

Vaginal infections: yeast trich bacterial gardnerella

STDS: Chlamydia Gonorrhea Herpes Veneral Warts/HPV Syphilis HIV

Pelvis: Ovarian cysts fibroids endometriosis

Are currently sexually active? Yes No Do you have pain with intercourse? Yes No

of partners in the last year? _____ In your life? _____ Age of first sexual activity? _____

Have you ever had an HIV test? Yes No If yes, date/result _____

What do you use for birth control? _____ Are you happy with this method? Yes No

Review of Systems:Please check symptoms you currently have or check negative.

1. Constitutional: Negative Fever Fatigue Change in height Weight gain Weight loss

2. Eyes/Ears/Nose/Throat: Negative Double vision Vision changes Earaches
 Hearing problems Sinus problems Mouth sores

3. Cardiovascular: Negative Chest pain/pressure Irregular Heartbeat
 Swelling of legs Short of breath on exertion

4. Respiratory: Negative Chronic cough Spitting up blood Painful breathing

5. Gastrointestinal: Negative Nausea/vomitting/indigestion Diarrhea
 Constipation Bloody stool Involuntary loss of gas or stool

6. Genitourinary: Premenstrual syndrome (PMS) Vaginal discharge
 Negative Pain with urination Frequent urination
 Strong urgency to urinate Lose urine with cough/sneeze/lifting
 Incomplete emptying Involuntary/unintended loss of urine

7. Musculoskeletal: Negative Muscle weakness Muscle/joint pain

8. Skin: Negative Rash Dry skin Moles

9. Breast: Negative Pain in breast Nipple discharge Lumps

10. Neurologic: Negative Memory problems Frequent headaches Dizziness

11. Psychiatric: Negative Depression/frequent crying Anxiety

12. Endocrine: Negative Hair loss Heat/cold intolerance Abnormal thirst

13. Hematologic/Lymphatic: Negative Frequent bruises Enlarged glands/lymph nodes

Physician reviewed with patient

Physician signature: _____ Nurse sig: _____

Date: _____