



Patient Name: _____

Date: _____

1
AGE: _____ D.O.B: _____ WEIGHT: _____ HEIGHT: _____

CHIEF COMPLAINT

MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Breast problems | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> HIV (AIDS) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach/ digestive problems | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Depression/ Bipolar disorder | | |

Other: _____

HOSPITALIZATIONS AND SURGERIES (type of surgery and year done):

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

CURRENT MEDICATIONS (list name, strength, & dosage):

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

ALLERGIES

IMMUNIZATIONS

Gardasil Yes _____ Dates _____ No _____

SOCIAL HISTORY (indicate how often):

- Smoker: No Yes If Yes, how many cigarettes a day _____
- Alcohol: No Yes If Yes, Social, occas., daily
- Drugs: No Yes If Yes, Which drugs: _____
- Exercise: No Yes If Yes, how many times per week: _____



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GYNECOLOGIC HISTORY (Please indicate if “yes” or “no” along with dates and duration of all that apply):

- When was your **last menstrual cycle**: _____
- **PMS Symptoms**: _____
- **Abnormal menstrual bleeding**: No Yes **Heavy Periods?** No Yes
- When was your **last pap smear**: _____
 - Have you ever had abnormal Pap smear results: No Yes
 - If yes, what was abnormal and when: _____
- When was your **last mammogram**: _____
 - Have you ever had abnormal mammogram results: No Yes
 - If Yes, What was abnormal: _____
- Any abnormal **vaginal discharge**: No Yes If yes, how long: _____
 - Are you currently sexually active: No Yes
 - Are you on any birth control: No Yes If Yes, which one: _____
- Any history of **sexually transmitted diseases (STD)**: No Yes
 - If Yes, Which one(s): _____
- Problems with **sexual function/arousal**: No Yes
 - If Yes, What exactly: _____
- Do you experience **pelvic pain** with
 - Intercourse Bowel Movements
 - Menstrual pains that impact your life



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OBSTETRICAL HISTORY:

- **Have you ever been pregnant?** No Yes
 If Yes, how many times: _____ How many living children? _____
 How many deliveries by: C- Section: _____ Vaginal birth: _____
- **Are you planning on having children in the future?** No Yes Maybe

URINARY/BOWEL:

- Do you have a history of **recurrent bladder infections**? No Yes
- Do you currently have any of the following when urinating:
 Burning- No Yes Frequency- No Yes Urgency- No Yes
- Do you currently have any involuntary **loss of urine** upon:
 Sneezing- No Yes Coughing- No Yes Running- No Yes
- Do you experience **involuntary loss of gas or stool**: No Yes

FAMILY HISTORY: Please specify

(Ex: heart disease, diabetes, high blood pressure, breast disease, cancer):

Breast Cancer: _____

Ovarian Cancer: _____

Endometrial Cancer: _____

Stomach/Colon Cancer: _____



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PLEASE FILL OUT ONLY IF YOU ARE OVER 50 OR MENOPAUSAL

IF 50 YEARS OF AGE OR MENOPAUSAL :

- Do you experience **hot flashes**? No Yes
- Do you experience **sexual dysfunction**: No Yes
 - If Yes, explain _____
- Do you experience **vaginal dryness**: No Yes
- Date and result of **last colonoscopy**: _____ Normal Abnormal
 - If abnormal, what was abnormal: _____
- Date and result of **last bone scan**? _____
 - Results were: Normal Osteopenia Osteoporosis
 - Do you take calcium and vitamin D supplements: No Yes
 - If yes, how much: _____
 - Age: _____ Weight: _____ Age at which menopause began: _____
 - Do you have a history of bone fractures: No Yes
 - Is there a family history of hip fractures: No Yes
 - If yes, who in the family: _____
 - Have you taken steroids for more than 3 months at a time: No Yes
 - Have you ever received chemotherapy in the past: No Yes