Suburban Gynecology & Urogynecology

PROUD TO BE AWARDED AAGL CENTER of EXCELLENCE in Minimally Invasive Gynecology

Patient Name: _____
Date: _____

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

CHIEF COMPLANT

_____

MEDICAL HISTORY

☐ Allergies	☐ High blood pressure	☐ Asthma
☐ Thyroid problems	☐ Seizure disorder	☐ Infertility
☐ Anemia	☐ Liver disease	☐ Hepatitis
☐ Breast problems	☐ Kidney or bladder problems	☐ HIV (AIDS)
☐ Diabetes	☐ Stomach/ digestive problems	☐ Blood disorder
☐ Heart disease	☐ Cancer	☐ High cholesterol
☐ 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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Patient Name: _____
Date: _____

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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Patient Name: _____
Date: _____

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☐

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