



Name first middle last Age Date

Occupation Marital Status: Single Married Divorced Widowed

Referred to our office by:

What is the purpose of your visit?

If you have a specific problem, please describe briefly:

How long have you had this problem?

Have you consulted anyone else? Yes No Who?

Describe any previous testing and/or treatment:

Please list all medications you are currently taking. Please include over the counter medications and herbal supplements.

Please list all allergies to medications, latex, iodine, foods:

GYNECOLOGY REVIEW

Last Pap Smear: Last Mammogram: Last Bone Density:

Date of last normal period: Age when your periods first started:

How often does your period come? Every days

How many days do you usually bleed?

I use pads and/or tampons on my heaviest days

Do you have significant pain with your periods? Yes No

Do you bleed or spot between periods? Yes No

Do you bleed or spot after sex? Yes No

Do you have to take any pain relievers during your period? Yes No

If yes, what do you usually take?

How much?

Patient Name _____ **DOB** _____

What form of birth control do you use?

Birth control pills – Name: _____ How many years? _____

IUD Type: _____ Date of insertion: _____

Vasectomy

Diaphragm

Rhythm/Natural Family Planning

Condoms/Foam/Suppositories

Tubal Ligation

Menopause

Hysterectomy

Not sexually active

Other: _____

Have you reached Menopause? Yes No Age of onset: _____

Do you have hot flashes? Yes No Night sweats? Yes No

Vaginal dryness/painful intercourse? Yes No Trouble sleeping? Yes No

Have you taken hormone replacement therapy? Yes No

Medication taken _____

Duration of treatment _____

Reason for discontinuation? _____

Herbal or natural supplements _____

Have you ever had an abnormal pap smear? Yes No What year? _____

Describe any treatment/follow-up: _____

Do you have a vaginal discharge? Yes No Describe: _____

Have you used medication for the discharge? Yes No Medication used: _____

Do you douche? Yes No If so, how often? _____ What do you use? _____

Have you been treated in the past for a vaginal infection? Yes No

Yeast

Chlamydia

HPV/genital warts

Trichomonas

Gonorrhea

Herpes/HSV virus

Syphilis

Bacterial/BV

Pelvic Inflammatory Disease

Do you have pain during or after intercourse on a regular basis? Yes No

Do you have any concerns with sexual function/desire? Yes No

Do you have concerns with PMS? Yes No

Have you ever been exposed to DES that you know of? Yes No

Do you have a history of physical/sexual/emotional abuse? Yes No

If yes, did you undergo counseling/treatment? Yes No

Is this something you would like to talk about? Yes No

Do you feel safe in your home? Yes No

Patient Name _____ **DOB** _____

Do you have concerns regarding your bladder? _____

Do you leak urine when you cough/laugh/exercise/sneeze/have sex? Yes No

How many times a day do you leak? _____

If you leak on a regular basis, do you leak small or large amounts? _____

Do you have to wear a pad regularly because of your leakage? Yes No

How many pads do you use in 1 day? _____

How many times a night do you get up to urinate? _____

If you need to urinate, can you make it to the bathroom or do you leak on the way? _____

Do you feel like you can completely empty your bladder? Yes No

Do you ever have to apply pressure to your bladder or have to change positions to empty your bladder?

Yes No

Do you ever have to apply pressure to your rectum to have a bowel movement? Yes No

Have you had a history of Urinary tract infections? Yes No

How many in the past year? _____

Have you ever seen a Urologist? Yes No

Have you ever had bladder testing? Yes No

Have you ever had surgery or treatment for any bladder issue? Yes No

Explain _____

Do you currently have:

_____ Burning with urination

_____ Blood in your urine

_____ Frequency

_____ Urgency

Do you perform monthly breast self-exams? Yes No

Any significant breast changes that you have noticed? Yes No

Do you have: breast lumps nipple discharge breast tenderness

SOCIAL HISTORY

Do you consume caffeine daily? Yes No Servings/day _____

Do you drink alcohol on a regular basis? Yes No Drinks/week _____

Do you smoke? Yes No Packs/day _____

Have you smoked cigarettes in the past? Yes No When did you quit? _____

Do you use drugs on a regular basis? Yes No

Type and how much? _____

Have you used IV drugs in the past? Yes No

Do you think yourself as: (*Response to this question is optional*)

Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Something else Don't know

Patient Name _____ DOB _____

OBSTETRICAL HISTORY

Please list pregnancies, miscarriages, and terminations from past to current:

Date	Length of pregnancy	D&C	Vaginal/C-Section	Girl/Boy	Weight	Complications

SURGERIES AND HOSPITALIZATIONS *(Use a separate piece of paper if more space is needed)*

Surgery/Hospitalization	Date	Reason/Diagnosis

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF NEEDED IN CASE OF EMERGENCY? YES NO

FAMILY HISTORY

Relationship	Age	Age at Death	Medical conditions
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Spouse			

Does anyone in your family have Breast Cancer? Yes No Who? _____

Does anyone in your family have Ovarian Cancer? Yes No Who? _____

Does anyone in your family have Colon Cancer? Yes No Who? _____

Does anyone in your family have Osteoporosis or Osteopenia? Yes No Who? _____

Patient Name _____ DOB _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypothyroid/Hyperthyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Lung Disease/COPD | <input type="checkbox"/> GERD/hiatal hernia |
| <input type="checkbox"/> Heart Disease/heart attack | <input type="checkbox"/> Lupus/Rheumatoid Arthritis/Sjogren's |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood clot/DVT/pulmonary embolus | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding disorder (Von Willebrands/Hemophilia) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> HIV/AIDS | |

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

Reviewed with patient _____ Date _____