



Medical History Form

(for new patients to the practice, or patients whom we haven't seen for more than a year)

This form asks you detailed questions about your gynecologic and general medical history. Some of the questions may seem very personal, and if you are not comfortable filling out any part of this form, please just leave it blank. (Remember that your gynecologist may ask you again about it, if it is especially relevant to your visit). The more complete the form, the easier it will be for your gynecologist to assess your situation in the context of your general health, and make the best medical recommendations possible in your situation.

REASON FOR VISIT:

- | | |
|--|---|
| <input type="checkbox"/> Annual physical/preventative exam | <input type="checkbox"/> Vulvar itching or discomfort |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Abnormal PAP smear |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Contraception/family planning |
| <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> No period for more than 3 months |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Diminished sex drive |
| <input type="checkbox"/> Urinary leaking or other problems | <input type="checkbox"/> Difficulty conceiving |
| <input type="checkbox"/> Pelvic prolapse | <input type="checkbox"/> Menopausal symptoms/hot flashes |
| <input type="checkbox"/> PMS/mood changes with periods | <input type="checkbox"/> Menstrual migraines |
| <input type="checkbox"/> Abnormal ultrasound/mass or cyst | <input type="checkbox"/> Recurrent pregnancy loss |
| <input type="checkbox"/> Other: (Please describe: _____) | |

Please be prepared to discuss the onset of your symptom(s), their duration, the impact that they've had on your lifestyle, what makes the symptom better or worse, what previous investigations or treatments you've had or tried. If you are still having periods, try to remember the dates of your last three periods and how long your menses lasted, and bring these dates with you to your visit.

GYNECOLOGIC HISTORY:

1. Birth Control history

(Check here if you have never been sexually active at any time in the past, and skip to Section IV – Menstrual History)

Birth Control Method (in last 3 months):

- | | |
|---|--|
| <input type="checkbox"/> None – not actively preventing pregnancy | |
| <input type="checkbox"/> Oral contraceptive pill (Which one? _____) | |
| <input type="checkbox"/> Not sexually active in last 3 months | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Depo-Provera |
| <input type="checkbox"/> Partner had vasectomy | <input type="checkbox"/> Ortho-Evra patch |
| <input type="checkbox"/> Natural family planning | <input type="checkbox"/> Vaginal ring (Nuvaring) |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Hysterectomy |

Which methods have you used in the past?

If you use, or have used oral contraceptive ("the pill"), for how many years have you done so? Which ones?

Are you satisfied with you current contraceptive method? Yes No/Unsure

If no or unsure, please explain:

Are you planning a pregnancy?

Do you consider your periods regular, occasionally irregular, or completely unpredictable?

Have you ever not had your period for more than 3 months when not pregnant or breastfeeding?

Any discomfort with menses? ___None ___Mild ___Moderate ___Severe

V. Preventative Tests

Year last PAP smear done? _____

Abnormal PAP in past? _____ If so, when?

How was it treated?

By whom?

Normal PAPs since?

Date of last mammogram? _____ Last thyroid check? _____

Date of last bone density? _____ Last cholesterol check? _____

Date of last sigmoidoscopy or colonoscopy? _____ Last glucose check? _____

PAST MEDICAL HISTORY:

Do you have (or have you had) any of the following medical conditions? (Please circle)

Thyroid disorder High blood pressure Heart disease Seizure disorder
Overweight Migraines Depression Asthma
Diabetes Osteoporosis High cholesterol Arthritis
Kidney problems Clotting disorder Bleeding disorder Stroke
Cancer (please specify type): _____
Other: _____

Please list surgeries:

Procedure done	Reason done	Surgeon	Year	Hospital	Complications

Please list any hospitalizations:

Reason for hospitalization	# Days in Hospital	Physician	Hospital	Year

Please list any medications you are currently taking:

Name of medication	Dose	When started	Why prescribed	Any side effects?

Please list any allergies (to medications, or to environmental factors):

Medication or other allergen	What is your allergic reaction to this substance/factor?

FAMILY HISTORY: (please check)

	Father	Mother	Sibling	Sibling	Mother's mother	Mother's father	Father's mother	Father's father
Thyroid disorder								
Anesthetic complication								
Overweight								
High blood pressure								
Birth defect								
Cancer								
Depression								
Substance abuse								
Bleeding disorder								
Clotting disorder								
Heart disease or stroke								
Diabetes								
Seizure disorder								
Other _____								

SOCIAL HISTORY /LIFESTYLE ISSUES

Do you smoke? ____Yes ____No
 If yes, how many cigarettes per day_____ For how many years? _____
 What methods have you used to try to quit? _____
 Have you ever smoked? ____Yes ____No
 If yes, how many cigarettes per day_____ For how many years? _____
 Do you use marijuana or other street drugs? ____Yes ____No
 How many alcoholic beverages per week do you consume on average? _____
 How many caffeinated beverages to you drink daily? _____
 Do you exercise regularly? ____Yes ____No
 If yes, what kind of exercise? ____ For how long at a time? ____ Times per week? ____
 Do you follow a well balanced diet? ____Yes ____No
 Any history of eating disorders? _____
 If overweight, what weight loss methods have you tried?

 Do you use seatbelts regularly? _____
 Do you have regular dental exams? _____ Regular eye exams? _____
 Are you currently under a lot of stress? ____Yes ____No
 If yes, please explain:
 Do you ever feel unsafe at home? Any domestic violence now or in the past? ____Yes ____No
 If yes, please explain, (or discuss at your visit):

Who currently lives at home with you? (Please list)

REVIEW OF SYSTEMS

Please circle any of the following symptoms you are experiencing at the present time. If they are relevant to this visit or need urgent attention, we will directly address them, or refer you to someone who can. Otherwise we will use them as clues as to whether an underlying medical disorder might be responsible for your gynecologic problem. It can also provide clues as to medication side effects.

<p><u>General</u> Intentional recent weight loss Unexplained recent weight loss Recent weight gain Fever/chills Recent change in energy level Recent change in appetite Nightsweats Other: _____</p>	<p><u>Eyes</u> Blurred vision Eye pain Other: _____</p>	<p><u>Ears, Nose, Throat, Mouth</u> Hearing loss Ringing in ears Earache Nasal congestion Frequent nosebleeds Sore throat Other: _____</p>
<p><u>Cardiovascular</u> Chest pain Rapid heartbeat Irregular heartbeat Swollen feet/ankles Leg cramps when walking Other: _____</p>	<p><u>Gastrointestinal</u> Abdominal pain Frequent heartburn Trouble swallowing food Nausea/vomiting Food intolerance Change in bowel habits Frequent constipation Frequent diarrhea Black or bloody bowel movements Bothersome hemorrhoids Other: _____</p>	<p><u>Urinary</u> Pain or burning with urination Urinary urgency Urinary frequency (more than 8X per day) Urinary tract infections (more than 3 per ye Leakage of urine with coughing Leakage of urine with urgency Blood in urine Foul smelling urine Other: _____</p>
<p><u>Respiratory</u> Chronic cough Wheezing Coughing blood Shortness of breath Other: _____</p>	<p><u>Musculoskeletal</u> Back pain Joint pain Joint stiffness Muscle aches Muscle weakness Other: _____</p>	<p><u>Skin</u> Rash Persistent itching Sores that don't heal New moles Changes in skin Other: _____</p>
<p><u>Breasts</u> Breast lumps Breast tenderness Nipple discharge Other: _____</p>	<p><u>Neurologic</u> Frequent headaches Seizures Tingling/numbness Tremors/balance problems Other: _____</p>	<p><u>Endocrine</u> Excessive thirst Excessive urination Heat intolerance Cold intolerance Other: _____</p>
<p><u>Hematologic/Lymphatic</u> Excessive bleeding Clotting disorder Easy bruising Swollen glands Other: _____</p>	<p><u>Immunologic/Allergic</u> Frequent sneezing Itchy eyes Frequent infections Eczema Latex sensitivity Other: _____</p>	<p><u>Mental Health</u> Trouble sleeping Severe mood swings Depressed mood Suicidal thoughts Frequent memory loss Increased irritability/anger Anxiety/panic attacks Difficulty concentrating Guilty feelings Other: _____</p>