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

Are your immunizations up to date? ☐ Yes ☐ No Have you received Gardisil? ☐ 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.

Type of surgery	*Date*
1	
2	
3	
4	
5	

Allergies

Are you allergic to **Food**? Yes No

List allergy and reaction:

_____

Are you allergic to **Medications**? Yes No

List allergy and reaction:

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

# of pregnancies?_____ Miscarriages?_____
Terminations?___
Ectopic (tubal) pregnancies?_____
Adopted Children?_____
Did you have gestational diabetes? ☐ Yes ☐ No
Did you have pre-eclampsia? ☐ Yes ☐ No

Please list deliveries:

Delivery date	*Vag. or C-sec.*	*Weight*
1		
2		
3		
4		
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 Nurse sig:_____

Physician signature: Date:_____