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Convenience • Caring • Cutting-Edge

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NEW GYN PATIENT HISTORY FORM
(OB PATIENTS, please DO NOT USE THIS FORM. Thanks.)

TODAY'S DATE _____ Your age_____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First)_____ (M.I.) _____

REFERRED HERE BY _____

YOUR PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X or a √)
Thank you for answering all of the following questions. Your health is important to us.

Breast Conditions
_____ Recent Mammogram When? _____
_____ History of Abnormal Mammogram
_____ Breast Cancer
_____ Breast Implants
_____ Fibrocystic Breast
_____ Other _____

Gyn Conditions
_____ Abnormal Pap Smear
_____ Endometriosis
_____ Fibroids
_____ Herpes (circle which type- oral and/or genital)
_____ HPV (Human Papilloma Virus)
_____ Menopause
_____ Ovarian Cysts or PCOS (polycystic ovary)
_____ Severe PMS
_____ Other _____

Heart or Circulation Conditions (Cardiovascular)
_____ Blood Clot (DVT or Pulmonary Embolism)
_____ Fainting (Syncope)
_____ High Blood Pressure
_____ Varicose Veins
_____ Other _____

Endocrine (Glandular) Disorders
_____ Diabetes (circle which type: Type 1 or Type 2)
_____ Pituitary Gland Disease
_____ Thyroid Disease
_____ Other _____

Immune System Diseases
_____ Lupus or Rheumatoid Arthritis
_____ Other _____

Gastrointestinal (GI) Problems
____ Blood in Stool
____ Crohn's Disease or Ulcerative Colitis
____ Hemorrhoids
____ Hepatitis
____ Irritable Bowel Syndrome
____ Had Colonoscopy? When? _____
____ Other _____

Blood (Hematologic) Disorders
____ Anemia
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other _____

Musculoskeletal Disorders
____ Fractures or Broken Bones
____ Arthritis or Joint Pain
____ Severe Back Pain or Back Disease
____ Other _____

Neurologic Disorders
____ Migraines or Severe Headaches
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other _____

Mental Health Conditions
____ Bipolar (Manic-Depressive)
____ Nervous Breakdown
____ OCD (Obsessive-Compulsive)
____ Severe Anxiety or Panic Attacks
____ Severe Depression or h/o Postpartum Depr.
____ Other _____

Respiratory (Lung) or ENT Disorders
____ Allergies, Hay Fever
____ Asthma
____ Bronchitis/Pneumonia
____ Lung Cancer
____ Sinusitis or Sinus Problems
____ Sleep Apnea
____ Other _____

Urinary (Urological) Disorders
____ Frequent Bladder Infections
____ Kidney Stones or Other Problems
____ Other _____

Skin Conditions
____ Acne (severe)
____ Eczema
____ Excess Hair Growth
____ Hives
____ Psoriasis
____ Other _____

What is your height? _____

What is your recent weight? _____

REVIEW OF SYSTEMS – RECENT ABNORMAL SYMPTOMS

(Are you currently experiencing any of the following symptoms to a significant degree?)
(If so, please indicate with an X or a √)

General
____ Fatigue or Weakness
____ Fever, Chills or Sweats
____ Loss of Appetite
____ Unexplained weight gain or loss

Eyes, Ears, Nose and Throat
____ Dizziness
____ Nose Bleeds
____ Sore Throat
____ Vision or Hearing Changes

Breasts
____ Breast Lump or Lumps
____ Breast Pain or Tenderness
____ Nipple Discharge (other than white)

Cardiovascular
____ Chest Pain or Tightness
____ Irregular Heartbeat or Palpitations

Respiratory
____ Chronic Coughing
____ Shortness of Breath
____ Wheezing

Gastrointestinal
____ Diarrhea (watery stool)
____ Heartburn
____ Nausea or Vomiting
____ Severe Constipation

Urinary
____ Burning with Urination
____ Frequent Urination
____ Urgency of Urination
____ Leakage of Urine
____ Waking at night 2 or more times to urinate

Gyn
____ Bleeding After Intercourse
____ Bleeding Between Periods
____ Bumps or Sores in Genital Area
____ Cycles Longer than 35 days?
____ Heavy Flow more than 3 days?
____ Pain Before or During Periods
____ Pain with Ovulation
____ Pain during intercourse
____ Periods last 8 or more days
____ Severe Pain or Cramps with Periods
____ Severe PMS Symptoms
____ Vaginal Discharge
____ Vaginal Itching, Burning or Dryness

Skin
____ Itching
____ Moles or Sores
____ Rash

Neurologic
____ Dizziness
____ Headaches
____ Memory Problems

Musculoskeletal
____ Joint Pain (Back, Knee, Wrist, Hip)
____ Joint Swelling
____ Muscle Cramping or Pain

Endocrine (Glandular)
____ Excessive Hair Growth
____ Excessive Hair Loss
____ Intolerance to Heat or Cold
____ Low Sex Drive

Psychiatric
____ Excessive Anxiety, Worries, Stress
____ Severely Depressed
____ Feeling Out of Control

PAST SURGERY or HOSPITAL ADMISSIONS

List all Surgeries or Hospital Admissions - EVER	Year

CURRENT PRESCRIPTION MEDICATIONS YOU ARE TAKING

Medication name, dosage (amount) and reason (include meds "as needed")
Recent Vaccines (Please enter here):

PHARMACY INFO (so we can E-prescribe for you)

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

Do we have permission to import your medication history using our electronic prescription software? YES NO

VITAMINS, HERBS AND SUPPLEMENTS YOU ARE TAKING

Product name and how often (include dosage if known)

ALLERGIES (circle choices)

If yes, please list all allergies and your allergic reaction

Do you have ANY allergies? NO ALLERGIES Allergic to Latex? YES NO

Allergic to	**Reaction**

FAMILY MEDICAL HISTORY

FOR THE ITEMS BELOW, PLEASE CONSIDER the following relatives: *(Yourself, Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews)*. This is a screening method to see if you are at increased risk for having a genetic mutation that can cause hereditary cancer.

CANCER RISK ASSESSMENT			Please Answer Yes or No, indicate age, and who has that specific condition.
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Breast Cancer**?	
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Colon Cancer or Endometrial Cancer**?	
Y	N	Have **YOU** or a **Family Member** had ten or more lifetime colon polyps (colorectal adenomas)?	
Y	N	Are **YOU** of Jewish ancestry *with* **Breast Cancer** in any **Family Member**?	
Y	N	Have **YOU or ANY FAMILY MEMBER** been diagnosed with **Ovarian Cancer** at any age?	
Y	N	Do you have **3 or more Family Members** with any of the below cancers on the same side of the family diagnosed at any age? ***Cancers: Breast, Colon, Endometrial (Uterine)***	
Y	N	Are there any **Men** in your family that have been diagnosed with **Breast Cancer**?	

OTHER CONDITIONS	Please CIRCLE CONDITION (on the left) and indicate below who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE	
3. ASTHMA or OTHER LUNG DISEASE	
4. KIDNEY DISEASE or KIDNEY STONES	
5. GYN DISEASES, OVARIAN, CERVICAL OR UTERINE CANCER, UTERINE FIBROIDS	
6. MUSCULOSKELETAL DISEASES, OSTEOPOROSIS OR OSTEOPENIA	
7. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
8. SEVERE DEPRESSION or OTHER MENTAL HEALTH CONDITION	
9. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
10. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
11. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	

Comments:

_____

SOCIAL HISTORY

Do you get 3 servings daily of dairy products (milk, yogurt, cheese, cottage cheese)? _____

Type of Exercise: _____ How Often? _____

Alcohol Intake: NONE or _____

Smoking History: NONE or _____

Drug Use: NONE or _____

Hazardous Exposures: NONE or _____

Your Occupation: _____

MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD _____ *CYCLE LENGTH (28 days or ?) _____

# of DAYS of BLEEDING during a *PERIOD _____ # days heavy_____ # days light/spotting _____

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) _____

BIRTH CONTROL METHOD _____ If none, please enter reason _____

LAST Pap Smear (MM/YY) _____ By who? _____

(***period** means # of bleeding days; **cycle length** means total # of bleeding & non-bleeding days until the next period begins)

PREGNANCY SUMMARY (how many…?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: _____

_____

PREGNANCY DETAILS

Child's Birthdate	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location