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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 gain or loss of weight

Eyes, Ears, Nose and Throat

- Dizziness
- Nose Bleeds
- Sore Throat
- Vision or Hearing Changes

Breasts

- Breast Lump
- Breast Pain or Tenderness
- Nipple Discharge (other than white)

Cardiovascular

- Chest Pain
- Irregular Heartbeat
- Palpitations

Respiratory

- Chronic Cough
- Shortness of Breath
- Wheezing

Gastrointestinal

- Diarrhea (watery stool)
- Heartburn
- Nausea or Vomiting
- Severe Constipation

Urinary

- Burning with Urination
- Frequent Urination
- Leakage of Urine
- Waking at night 2 or more times

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
- Periods last 8 or more days
- Severe Cramps with Periods
- Vaginal Discharge

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
- Hair Falling Out
- Intolerance to Heat or Cold
- Low Sex Drive

Psychiatric

- Excessive Anxiety, Worries, Stress
- Severely Depressed
- Feeling Out of Control

Patient Name _____

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

Patient Name _____

FAMILY MEDICAL HISTORY

FOR THE BELOW, PLEASE CONSIDER 1st and 2nd Degree Relatives:

(Yourself, Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews)

CANCER RISK ASSESSMENT			Please <u>Answer Yes or No</u> , indicate age, and who has that specific condition.
Y	N	Have YOU or a Family Member ever been diagnosed with Breast Cancer under age 45?	
Y	N	Have YOU or a Family Member ever been diagnosed with Colon Cancer or Endometrial Cancer under age 50?	
Y	N	Have YOU or a Family Member had ten or more lifetime colon polyps (colorectal adenomas)?	
Y	N	Are YOU of Jewish ancestry <i>with Breast Cancer</i> in a Family Member at any age?	
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	
Y	N	Are there any Men in your family that have been diagnosed with Breast Cancer ?	

OTHER CONDITIONS	Please <u>CIRCLE CONDITION</u> (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:

Patient Name _____

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SOCIAL HISTORY

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

Amount and Type of Exercise: _____ How Often? _____

Alcohol Intake: NONE or _____

Smoking History: NONE or _____

Illicit Drugs 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

Form Revised July 2016

Patient Name _____

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