GYN Surgical Specialists

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THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.
COMPLETE AND ACCURATE INFORMATION ALLOWS US TO GIVE YOU THE BEST CARE POSSIBLE.

Date:_____ Referring Physician:_____

**MAIN REASON FOR VISIT:**

☐ Annual exam ☐ Urinary incontinence ☐ Pelvic pain ☐ Breast issue ☐ Vaginitis/itching ☐ Pelvic mass
☐ Elevated Ca125 ☐ Vaginal bleeding ☐ Abnormal Pap smear ☐ Fibroids ☐ Vulvar problem
☐ Other _____
_____

**OBSTETRICAL HISTORY:**

How many pregnancies have you had? _____ Vaginal deliveries _____ C-sections _____ Tubal pregnancies _____
Miscarriages _____ Abortions _____ Stillbirths _____

**GYNECOLOGICAL HISTORY:**

Age at first period: _____ Date of last menstrual period:_____
If not menstruating, stopped at age: _____ because of ☐ menopause ☐ uterus removed for_____(reason)
Are your periods ☐ regular ☐ somewhat irregular ☐ very irregular?
How many days between the first day of one period and the first day of your next period? _____
Menstrual flow usually lasts for _____ days total and is ☐ scant ☐ moderate ☐ heavy ☐ excessive with clots
Have you missed a period without being pregnant? ☐ Yes ☐ No
Are your currently sexually active? ☐ Yes ☐ No
How do you prevent pregnancy? ☐ birth control pills ☐ condoms ☐ IUD ☐ tubal ligation ☐ menopause/uterus removed
☐ No method ☐ Other_____
Date of last Pap smear: _____ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No Treatment _____

**MEDICAL PROBLEMS:** Check any problem you have been diagnosed with or received treatment for:

☐ Anemia
☐ Heart attack
☐ Heart murmur
☐ Congestive heart failure (CHF)
☐ Angina
☐ High blood pressure
☐ Atrial fibrillation
☐ Mitral valve prolapse
☐ Asthma
☐ Allergies/hay fever
☐ Bronchitis
☐ Emphysema
☐ COPD
☐ Diabetes
☐ Thyroid
☐ Bone disease/osteoporosis
☐ Previous cancer_____(type)
☐ Jaundice/cirrhosis
☐ Gallstones
☐ Stomach ulcer
☐ Hernia
☐ Irritable bowel syndrome
☐ Colitis _____
☐ Chronic diarrhea
☐ Hemorrhoids
☐ Arthritis
☐ Fibromyalgia
☐ Sjogren's syndrome
☐ Back/neck/spine problems
☐ Migraines _____ (how often?)
☐ Seizures
☐ Kidney failure
☐ Kidney stone
☐ Blood clot in leg or lung
☐ Phlebitis
☐ Bleeding disorder (van Willebrand)
☐ Varicose veins
☐ Glaucoma
☐ Skin disease _____
☐ Depression
☐ Anxiety
☐ Bipolar
☐ Schizophrenia
☐ Dementia/Alzheimer's
☐ Other _____

Height: _____ Current Weight: _____ Usual Weight: _____ Age: _____

Patient Name_____ Date of Birth _____



**PATIENT HISTORY & PHYSICAL FORM**

**MEDICATIONS AND SUPPLEMENTS:** Please list all medications, supplements and herbs.

| | Name of Medication | Dosage | When do you take it? | Who prescribed it? |
|---|---|---|---|---|
| Diabetes | | | | |
| Heart/Blood Pressures | | | | |
| Anxiety/ Depression | | | | |
| Other | | | | |
| Over the Counter | | | | |
| Herbs/Vitamins/ Supplements | | | | |

**Preferred Pharmacy:**

☐ CVS ☐ Rite Aid ☐ Walmart ☐ Kroger ☐ Publix ☐ Walgreens ☐ Other_____

Address: _____ Phone: _____

**ALLERGIES:** Please list all allergies to medications, food and materials (i.e., latex, adhesives, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.).

| Medication and Reaction | Medication and Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

Patient Name_____ Date of Birth _____

**DOCTORS:** Please list the doctors who care for you.

| Specialty: | Name | Phone | Send notes?* |
|---|---|---|---|
| Gyn | | | ☐ Yes ☐ No |
| Primary Care | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

*Mark yes if you would like us to send information to your other doctors after each office visit.

**INFECTIOUS DISEASE:** Check any of the following that you have had:
☐ Pneumonia ☐ Rheumatic Fever ☐ Tuberculosis ☐ Herpes, last outbreak_____ ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea ☐ HIV ☐ Hepatitis type_____ ☐ Tubal Infection (PID) ☐ Frequent bladder or kidney infections or one treated in the hospital ☐ Abscess, describe: _____

**SCREENING AND DIAGNOSTIC TESTS:**
Date of last mammogram: _____ Date of last colonoscopy:_____
In the last year, have you had any ☐ X-Rays ☐ CT scans ☐ MRI scans ☐ Ultrasounds (sonograms)?
If yes, list body part imaged and the facility where performed: _____
_____

**SURGERY:** Please list all previous surgeries.

| Year | Gyn/Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-section) | Year | Orthopedic Surgery (knee, hip replacement, back or bone surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| Year | Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder) | Year | Other Abdominal Surgery (colon, hernia, bowel stomach, gallbladder) |
| | | | |
| | | | |
| | | | |
| | | | |
| Year | Other Surgery (eye, lung, kidney, etc.) | | |
| | | | |
| | | | |

Have you ever been advised to have any surgical procedure which has not been done? ☐ No ☐ Yes:_____
_____
Have you ever. been hospitalized for any illnesses? ☐ No ☐ Yes, reason/year:_____
Have you ever had a blood transfusion? ☐ No ☐ Yes, year:_____

Patient Name_____ Date of Birth _____

**FAMILY HISTORY:** Please list any family member diagnosed with these diseases and whether they are alive (A) or deceased (D) from the disease.

| | Close Family Members (child, sibling or parent) | Extended Family Members (aunts, uncles, grandparents, cousins) |
|---|---|---|
| Ovarian Cancer | | |
| Breast Cancer | | |
| Endometrial Cancer | | |
| Cervical Cancer | | |
| Prostate Cancer | | |
| Colon Cancer | | |
| Other Cancer | | |
| Diabetes | | |
| Tuberculosis | | |
| Stroke | | |
| High blood pressure | | |
| Heart attack | | |

**SOCIAL HISTORY:**

Do you smoke? ☐ Yes ☐ No Packs per day: _____ Number of years: _____ When did you quit? _____
Do you use any other form of tobacco? ☐ Yes ☐ No If yes, type: _____
Do you use alcohol? ☐ Yes ☐ No Amount per week? _____ Type: _____
Have you ever used drugs? ☐ Yes ☐ No ☐ Past ☐ Present What type? _____
Do you exercise routinely? ☐ Yes ☐ No How often per week? _____ What type? _____
Do you have concerns about your personal safety, the personal safety of anyone in your home, or the security of your property? ☐ Yes ☐ No

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner
**Ages of children:** _____
**Education:** ☐ High school ☐ College ☐ Graduate school
**Occupation:** _____ ☐ Retired ☐ Disabled due to_____

Patient Name_____ Date of Birth _____

**SYSTEM REVIEW:** Check any of the following symptoms that you have now or have had in the past six months.

| | | | |
|---|---|---|---|
| General | ☐ fevers | ☐ weight loss _____ lbs | ☐ weight gain_____ lbs |
| | ☐ weakness/ excessive fatigue | | |
| Skin | ☐ sores | ☐ rashes | ☐ itching |
| | ☐ new moles or freckles | ☐ loss of skin pigment | |
| Neurologic | ☐ seizures/convulsions | ☐ tremor | ☐ severe headaches |
| | ☐ numbness/tingling | ☐ loss of consciousness/fainting | |
| Eyes, Ears, | ☐ ringing in the ears | ☐ any eye disease or injury | |
| Nose, Throat | ☐ chronic sinus infections | ☐ any ear disease or injury | |
| | ☐ frequent throat infections | Do you wear glasses? ☐ Yes ☐ No | contacts? ☐ Yes ☐ No |
| | | dentures? ☐ Yes ☐ No | hearing aids? ☐ Yes ☐ No |
| Breasts | ☐ nipple discharge | ☐ change in breast size | ☐ new or changing lumps |
| Respiratory | ☐ shortness of breath | ☐ chronic or frequent cough | ☐ bloody sputum |
| Cardiovascular | ☐ chest pain | ☐ rapid/irregular heartbeat | ☐ swelling of feet or ankles |
| Gastrointestinal | ☐ diarrhea | ☐ constipation | ☐ nausea |
| | ☐ vomiting | ☐ heartburn or indigestion | ☐ difficulty swallowing |
| | ☐ blood in stool | ☐ black or tarry stool | ☐ abdominal cramps or pain |
| | ☐ unable to control bowels | ☐ urgency of bowel movements | |
| Gynecologic | ☐ pelvic pain | ☐ bleeding/spotting between periods | |
| | ☐ painful sex | ☐ bleeding/spotting after sex | ☐ painful periods |
| | ☐ vaginal irritation/itching | ☐ vaginal discharge | ☐ vaginal dryness |
| | ☐ vulvar irritation/itching | ☐ bulging sensation in vagina | ☐ lumps in groin |
| | ☐ sores or lumps around the vulva or vagina | | |
| Urinary | ☐ frequent urination | ☐ painful urination | ☐ night urination |
| | ☐ dribbling of urine | ☐ sudden urgent need to urinate | |
| | ☐ bedwetting | ☐ loss of urine with sneezing or coughing | |
| Musculoskeletal | ☐ back pain | ☐ joint pain/stiffness | ☐ leg cramps or limp |
| | ☐ muscle weakness | | |
| Endocrine | ☐ unusual hair growth | ☐ hair loss | ☐ abnormal thirst |
| | ☐ salt cravings | ☐ hot flashes | |
| Psychiatric | ☐ nightmares | ☐ insomnia | ☐ depression .. |
| | ☐ excessive worry/stress/tension | | |

Patient Name_____ Date of Birth _____