MEDICAL INFORMATION

Patient Name:	**DOB:**	**Age:**	**Weight:**	**Height:**

Reason for your visit today:	**How long have you had this problem:**
Are you under the care of any other physician?	**If yes, Please give reason:**
Doctor Name:	

First day of last period:	**Do you have regular monthly periods?** □ **Yes** □ **No**	**How often do your periods come?**	**Age of first period?**
Periods are: □ **Mild** □ **Moderate** □**Heavy**	**How many days do your periods last?**	**Cramps are:** □ **Mild** □ **Moderate** □ **Severe**	

Do you have headaches with your periods? □ **Yes** □ **No**	
Current Birth Control:	**Are you happy with this birth control?** □ **Yes** □ **No**
Age at First intercourse: **Number of partners(lifetime):**	**Have you had a new sexual partner since your last exam?** □ **Yes** □ **No**
Do you desire testing for STD's □ **Yes** □ **No**	

Last Pap Smear: ___/___	**Have you ever had an abnormal Pap?** □ **Yes** □ **No**	**If yes, Please give year and any procedures:**
Last Mammogram: ___/___	**Have you ever had an abnormal Mammogram?** □ **Yes** □ **No**	**If yes, Please give year and any procedures:**
Last Colonoscopy: ___/___	**Last bone Density: ___/___**	**Have you ever had an abnormal Bone Density?** □ **Yes** □ **No**

Allergies:	**Reaction:**

Medications:	**Hospitalizations/Surgeries (list all except for pregnancy):**	**Date of surgery**

Have you ever been put to sleep? □ **Yes** □ **No**	**Had a reaction to anesthesia?** □ **Yes** □ **No**	**Have you had?** □ **Epidural** □ **Spinal Anesthesia**

Do you currently: □ **Exercise regularly** □ **Diet-What type?_____** □ **Drink Alcohol How much?_____** □ **Use Recreational Drugs?**	**Smoking History:** **Do you currently smoke? _____ If yes, _____ packs/day** **Have you ever smoked? _____ If yes, _____ packs/day**	**Do you do monthly breast exams?** □ **Yes** □ **No**

MEDICAL HISTORY CONTINUED

Name: **DOB:**

Are you experiencing any of the following:
□ Leak urine when you cough/laugh/sneeze
□ Unaware that you are leaking urine
□ Strong urge to urinate
□ Wear a pad because of urine leakage
□ Leaking after intercourse
□ Painful urination
□ Incomplete urination
□ Bloody urine
□ Difficulty beginning to urinate
□ Slow Urination
□ Straining to pass urine
□ Irregular Periods
□ Pain with your menses
□ Pain with ovulation
□ Dissatisfied with sexual relations
□ Pain with intercourse
□ Bleeding between periods
□ Bleeding after intercourse
□ Bleeding from your rectum

Continued:
□ Vaginal discharge
□ Vaginal itching
□ Vaginal burning
□ Breast/Nipple discharge
□ Lump(s) in breast
□ Breast Pain
□ Hot flashes
□ Trouble sleeping
□ Vaginal dryness
□ Night Sweats
□ Feel anxious
□ Feel sad/depressed
□ feeling of pressure or bearing down
□ Bulging from your vagina
□ Unusual hair growth
□
□

Please check the box if you have had problems with the following:
□ Skin
□ Eyes/vision
□ Ears/hearing
□ Mouth/teeth
□ Anemia
□ Cancer-What kind?_____
□ Diabetes
□ Thyroid Disease
□ Seizures/Epilepsy
□ Migraines
□ Rheumatic fever
□ Phlebitis

□ Psychiatric problems
□ Depression
□ High cholesterol
□ Heart disease
□ High blood pressure
□ Asthma
□ Bleeding problems
□ Blood transfusions
□ Hepatitis
□ Lung disease
□ Breast Lump
□ Breast discharge
□ Breast surgery
□ Heart murmurs

□ Gall bladder disease
□ Stomach Ulcer
□ Black/Bloody stool
□ Kidney
□ Bladder infections
□ Gonorrhea
□ Syphilis
□ PID
□ Hepatitis B
□ Trichomonas
□ HPV
□ Chlamydia
□ Genital warts
□ Herpes

□ HIV/AIDS
□ Broken bones
□ Back pain
□ Joint problems
□ Arthritis
□ Vaginal infections
□ Pelvic tumor
□ Pelvic infections
□ Abnormal Paps
□ Endometriosis
□ Fibroids
□ Ovarian tumors
□ Breast biopsy

Incontinence Questionnaire:
Please answer as accurately as possible.
1. Do you leak urine when you cough, sneeze or laugh? □ Yes □ No
2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? □ Yes □ No
3. If "yes" to #2 do you ever leak before you get to the toilet? □ Yes □ No
4. How many times do you void during the night after going to bed?____
5, How many times during the day do you urinate? _____
6, Have you wet the bed in the past year? □ Yes □ No
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? □ Yes □ No
8. Do you ever leak during or after sexual intercourse? □ Yes □ No
9. Do you find it necessary to wear a pad because of you leaking? □ Yes □ No
10. How many times do you leak during the day? _____
11. Have you had bladder, urine, or kidney infections? □ Yes □ No
12. Are you troubled by pain or discomfort when you urinate? □ Yes □ No
13. Have you had blood in you urine? □ Yes □ No
14. Dou you find it hard to begin urinating? □ Yes □ No
15. Do you have a slow urinary stream? □ Yes □ No
16. Do you have to strain to pass you urine? □ Yes □ No

Family History

Are you adopted? □ Yes □ No

Pleas check all that apply under the appropriate family member: **(for brother and sister please list which sibling or both)**

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/Lung Problems									

Birth Defects									
Bleeding Problems									
Blood Clots									
Bloody Stools/Colon Polyp(s)									
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Depression									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease/UTI's									
Liver Disease									
Loss of Urine									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Seizures									
Stomach Ulcers									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									

Other (please explain):

REPRODUCTIVE HISTORY

Pregnancy Summary: Last Menstrual Period:

Total Pregnancies:	Total Full Term Pregnancies:	Total Premature Deliveries:	Total Elective Terminations:	Total Spontaneous Terminations (Miscarriages):	Total Ectopic Pregnancies:	Total Living Children:

Date of Birth:	Gestational Age in weeks:	Hours in labor:	Birth Weight:	Sex:	Delivery Type (Vaginal or Cesarean):	Anesthesia Received (i.e. Epidural)	Early Labor:	Comments or Complications:	Delivery Location:
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		