Date

Patient Information and Authorization

Name______________________________ Date of Birth __________ SS#__________

Reason for visit Check all that apply

- O Annual exam
- O New Patient
- O Urinary incontinence
- O Bleeding (Menstrual) issues
- O Contraception consult
- O Fertility consult
- O Pelvic Pain
- O Pregnancy consult
- O Menopause consult

Other______________________________

For New Patients

Please list any Past Surgeries:

Date_______ Surgery ______________________
Complaint ______________________

Date_______ Surgery ______________________
Complaint ______________________

Date_______ Surgery ______________________
Complaint ______________________

Date_______ Surgery ______________________
Complaint ______________________

Health Habits – Are you currently:

- O Smoking , how much ______________
- O Drinking alcohol, how much ______________
- O Using drugs, what kind______________
- O Exercising, how often______________
- O Doing self breast exams
- O Being sexually or physically abused ______________

Obestrical History:

O I have never been pregnant

Total number of pregnancies ______________

Please list all pregnancies in order including miscarriages and abortions:

Date: _______ Outcome______________
Date: _______ Outcome______________
Date: _______ Outcome______________
Date: _______ Outcome______________
Date: _______ Outcome______________
Date: _______ Outcome______________

Gynecologic

Menstrual

How old were you when you started your menses?

I get my period every_____days. Are your menses are irregular? O yes O no

Do tampons or sanitary napkins quickly become soaked? O yes O no

Do you experience heavy bleeding with clotting? O yes O no

Do you experience bleeding between periods? O yes O no

Are you exceptionally tired or weak during your period? O yes O no

Are you periods painful? O yes O no

Have you missed work or stayed home because of your period? O yes O no

Reproductive

What form of birth control are you using?

- O Pills type______________
- O IUD type______________
- O Nuvaring
- O Other type______________
- O Essure when______________
- O Tubal when______________
- O Vasectomy when______________

Age of first intercourse: _________ Number of partners:________ Sexually Active________

Is your family complete?

- O Yes
- O No
- O Trying to conceive now
- O Undecided/Does not apply

History of STD's______________

General

Are you experiencing any of the following:

- O Vaginal discharge
- O Vaginal dryness
- O Breast pain/tenderness
- O Genital itching
- O Nipple discharge
- O Hot flashes
- O Breast lumps
- O Genital lesions
- O Bleeding/painful sex
- O Lack of libido
- O Pelvic pain
- O Other

Urologic

Have you experience unplanned, sudden urine leakage? O yes O no

Do you experience leakage while laughing, sneezing or jumping? O yes O no

Do you frequently experience a sudden and immediate urge to urinate? O yes O no

Do you experience painful urination? O yes O no

Is there ever blood in your urine? O yes O no

Gastrointestinal Are you experiencing any of the following:

- ○Vomiting
- ○Diarrhea
- ○ Straining during bowel movements
- ○Constipation
- ○Abdominal pain
- ○Other________________
- ○Problems swallowing
- ○Blood in stool/bowel

Constitutional Have you experienced any of the following:

- ○Fever
- ○Fatigue
- ○Other
- ○Night sweats
- ○Weight loss or gain

Dermatologic ○Itching ○Rash ○Other________________

Musculoskeletal ○Bone/joint pain ○Muscle weakness ○Other________________

Respiratory ○Cough ○Wheezing ○Other________________ ○Difficulty breathing ○Shortness of breath ○Smoking

Cardiovascular ○Chest pain ○Palpitations ○Other________________

Metabolic ○Heat intolerance ○Thirsty ○Other________________ ○Cold intolerance ○Weight gain/loss ○Unusual hair loss/growth ○Easy bleeding/bruising

Neuro/ Psychiatric ○Dizziness ○Seizures ○ Sadness/depression ○Anorexia/bulimia ○Anxiety Other________________ ○Migraines/headeaches

Immunologic ○Allergies including food/environment? List________________

Have you had a tetanus shot in the last 10 years? ○yes ○no

List any medications you are currently taking. Including alternatives and over-the-counter medications (Medication, Dose and Start Date)

____

____

List any medical allergies and what they do to you

____

____

Have you or a member of your family had any of the following:

	Self	Family Member
Alzheimer's		
Anemia		
Anxiety/Depression		
Autoimmune Disease		
Arthritis		
Asthma		
Birth defects		
Bleeding/Clot Disorders		
Bleeding tendencies		
Blood transfusion		
Bowel Problems		
Cancer (type?)		
Chest Pain		
Depression		
Diabetes		
Dizziness/fainting		
Fever		
Heart Disease		
Hepatitis		

	Self	Family Member
High Cholesterol		
Hypertension		
Kidney disease		
Liver disease		
Lung disease		
Musculoskeletal disorder		
Neurological disorder		
Seizer/epilepsy		
Shortness of breath		
Stomach/GI disorder		
Stroke		
Tuberculosis		
Urinary tract infection		
Weight gain		
Weight loss		
Other		