

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for Today's visit: \_\_\_\_\_

**GYNECOLOGIC HISTORY:** Check if you have had any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chlamydia                   | <input type="checkbox"/> Pain with sex               | <input type="checkbox"/> Bacterial vaginosis (BV)       |
| <input type="checkbox"/> Gonorrhea                   | <input type="checkbox"/> Ovarian cyst                | <input type="checkbox"/> Abnormal Pap test              |
| <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Chronic pelvic pain         | <input type="checkbox"/> Recurrent vaginitis            |
| <input type="checkbox"/> HIV                         | <input type="checkbox"/> Premenstrual syndrome (PMS) | <input type="checkbox"/> Vaginal dysplasia (pre-cancer) |
| <input type="checkbox"/> HPV/genital warts           | <input type="checkbox"/> Infertility                 | <input type="checkbox"/> Vulvar dysplasia (pre-cancer)  |
| <input type="checkbox"/> Syphilis                    | <input type="checkbox"/> Urinary incontinence        | <input type="checkbox"/> Vulvar pain                    |
| <input type="checkbox"/> Trichomonas                 | <input type="checkbox"/> Endometriosis               | <input type="checkbox"/> Other: _____                   |
| <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Abnormal uterine structure  |   |
| <input type="checkbox"/> Uterine fibroids            | <input type="checkbox"/> Yeast                       |   |

Last Menstrual Period: \_\_\_\_\_

**MEDICAL HISTORY:** Have there been any changes? Check all that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> None                               | <input type="checkbox"/> Depression           | <input type="checkbox"/> Migraines                   |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Osteopenia                  |
| <input type="checkbox"/> Hypertension (High blood pressure) | <input type="checkbox"/> Fibroids             | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Other, please specify _____ |
| <input type="checkbox"/> Cancer (type) _____                | <input type="checkbox"/> Sleep Apnea _____    |  |

Last Pap smear: \_\_\_\_\_ was it abnormal?  NO  YES if yes, explain: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_ was it abnormal?  NO  YES if yes, explain: \_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_ was it abnormal?  NO  YES if yes, explain: \_\_\_\_\_

**SEXUAL HISTORY:**

Are you sexually active?  NO  YES      Have you ever been sexually active?  NO  YES

Have your partner (s) in the past/present been  MALE  FEMALE  BOTH

Do you have concerns about sexually transmitted infections?  NO  YES  UNSURE

Do you or your partner have more than one partner?  NO  YES

What method of birth control, if any, are you using? \_\_\_\_\_

What birth control, if any, have you used in the past? \_\_\_\_\_

**SURGICAL HISTORY:**

Have there been any changes to your Surgical History?  NO  YES

- If Yes , list procedure, year and hospital

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**FAMILY HISTORY:**

Have there been any changes to your Family History?  NO  YES if yes, please indicate below

ILLNESS	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER
Diabetes							
Heart Disease							
Cancer (type)							
Mental health disease							
Other: Specify							

**Allergies (Medication and Environmental):** \_\_\_\_\_

**Current Medications (include all prescription, over the counter and topical medications):**

Do you have changes to your current medications?  NO  YES if yes, please indicate below

Medication	Dose and Frequency	Condition

Pharmacy Name

Address

Telephone Number

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please check all symptoms that you are currently experiencing:

**Constitutional**-----

- Fever
- Chills
- Malaise
- Fatigue
- Anorexia
- Unintended weight gain

**Head and Face**-----

- Facial Pain
- Facial Pressure

**Eyes**-----

- Eye pain
- Red eyes
- Discharge from eyes
- Itchy eyes
- Blurred vision
- Vision changes
- Corrective lenses

**ENT**-----

- Earache
- Loss of hearing
- Ringing ears
- Runny nose
- Nasal congestion
- Sore throat
- Scratchy throat
- Change in voice/hoarseness
- Dentures

**Cardiovascular**-----

- Chest pain
- Racing heart
- Leg pain
- Leg swelling
- Lightheadedness/Fainting
- Poor exercise tolerance

**Respiratory**-----

- Shortness of breath
- Wheezing
- Sleeping upright/extra pillow
- Cough
- Dry cough
- Productive cough
- Clear sputum
- Colored sputum
- Vomiting blood
- Daytime sleepiness

**Gastrointestinal**-----

- Decreased appetite
- Difficulty swallowing
- Esophageal reflux
- Abdominal pain
- Abdominal bloating
- Abdominal cramps
- Menstrual pain
- Nausea
- Vomiting
- Diarrhea
- Unable to pass flatus
- Constipation
- Dark/bloody stools
- Rectal bleeding
- Change in color/size of stool
- Fecal incontinence

**Genitourinary**-----

- Difficult/painful urination
- Loss of urine
- Urinary hesitancy
- Urinary urgency
- Frequent urination
- Night time urination
- Dark urine
- Blood in urine
- Flank pain
- Suprapubic pain
- Pelvic pain
- Foul-smelling vaginal discharge
- Heavy menstrual bleeding
- Painful menstrual cramps
- Missed menstrual period
- Suspected pregnancy
- Confirmed pregnancy
- Difficult/painful intercourse
- Postmenopausal bleeding

**Musculoskeletal**-----

- Joint pain
- Joint swelling
- Joint stiffness
- Muscle pain
- Back pain
- Limping
- Falls

**Skin/Breast**-----

- Skin rash
- Itchy skin
- Skin wound/ulcer
- Skin lesions
- Mouth sores
- Redness
- Swelling
- Scaling
- Blisters
- Breast pain
- Breast lump
- Nipple discharge

**Neurologic**-----

- Frequent headaches
- Migraines
- Memory loss/confusion
- Dizziness
- Burning/prickling sensation
- Leg numbness
- Leg weakness
- Tingling
- Difficulty walking
- Vertigo
- Tremors

**Psychiatric**-----

- Insomnia
- Irritable
- Anxiety
- Depression
- Sleep disturbances
- Overwhelming stress
- Suicidal ideation

**Endocrine**-----

- Hot flashes
- Night sweats
- Heat/cold intolerance
- Abnormal thirst
- Decreased libido
- Excessive facial/chest/back hair
- Muscle weakness
- Generalized weakness

**Hematology/Lymph**-----

- Swollen lymph nodes
- Bleeding gums/Nose bleeds
- Easy bleeding
- Easy bruising
- Jaundice