

MEDICAL AND GYNECOLOGIC HISTORY

DATE: _____ NAME: _____ DOB: _____

REVIEWED WITH PATIENT

☐ DR. DUNTON ☐ DR. HOLTZ ☐ DR. STAMPLER ☐ DR. STICKLES ☐ DR. WANG

CURRENT GYNECOLOGIC PROBLEM OR REASON FOR CONSULTATION:

Date of last menstrual period _____ Age at first period _____ Menopause age (if applies) _____

Days between periods _____ How long do your periods last _____

How many pregnancies _____ How many deliveries _____ How many miscarriages/terminations _____

Bleeding between periods? ☐ Yes ☐ No

Painful periods? ☐ Yes ☐ No

Pre-menstrual syndromes? ☐ Yes ☐ No

Bleeding with intercourse? ☐ Yes ☐ No ☐ N/A

Pain with intercourse? ☐ Yes ☐ No ☐ N/A

Did your mother take DES when
pregnant with you? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No If yes, method of contraception _____

Is your current partner? ☐ Male ☐ Female ☐ Both

Have you received the HPV vaccine? ☐ Yes ☐ No

History of sexually transmitted disease (i.e. gonorrhea, chlamydia, herpes, syphilis)? ☐ Yes ☐ No

Date of last PAP Smear _____

Have you ever had an abnormal PAP Smear? ☐ Yes ☐ No

If yes, when and how was it treated? _____

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No

Date of last mammogram _____ Date of last DEXA _____ Date of colorectal screening _____

ALLERGIES TO MEDICATIONS/FOODS

ALLERGY

REACTION

1. _____

2. _____

3. _____

NAME: _____

DOB: _____

MEDICAL PROBLEMS:

Kidney Disease ☐ Yes ☐ No

Lung Disease ☐ Yes ☐ No

Heart Disease (i.e. heart attack, irregular heart rate, heart failure, pacemaker) ☐ Yes ☐ No

Lung Disease (i.e. asthma, COPD) ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

Liver Problems (i.e. hepatitis) ☐ Yes ☐ No

Blood clots ☐ Yes ☐ No

Cancer ☐ Yes ☐ No If yes, what kind and treatment received? _____

Thyroid ☐ Yes ☐ No

Sleep Apnea ☐ Yes ☐ No If yes, do you use CPAP or BIPAP? ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No

Gastrointestinal Problems (i.e. ulcer, acid reflux, Crohns disease, celiac) ☐ Yes ☐ No

Infections such as MRSA, C.difficile ☐ Yes ☐ No

Bleeding or Blood Clotting Disorder ☐ Yes ☐ No

Other _____

PAST SURGERIES OR HOSPITALIZATIONS (other than current illness):

Dates	Hospital	Procedure
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_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS:

Tobacco ☐ Yes ☐ No ☐ Quit	number of packs/day _____	number of years _____
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Drugs ☐ Yes ☐ No ☐ Quit		
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Alcohol ☐ Yes ☐ No ☐ Quit	number of drinks per day/week _____
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Exercise ☐ Yes ☐ No	number of days per week _____
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OCCUPATION: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Long term relationship

FAMILY HISTORY:

Do any family members (including aunts, uncles, cousins, nieces, nephews) have?

☐ Breast cancer ☐ Ovarian cancer ☐ Colon cancer ☐ Uterine cancer

Is there a family history of: ☐ Diabetes ☐ Heart Disease ☐ Blood clots/bleeding disorder

OTHER FAMILY HISTORY: _____

NAME: _____

DOB: _____

REVIEW OF SYSTEMS**BREAST EVALUATION:**Breast exams monthly? ☐ Yes ☐ No (If no, please ask for information)Any previous abnormalities or recent changes? ☐ Yes ☐ No Previous biopsies? ☐ Yes ☐ No**LUNGS:**Do you have a chronic cough? ☐ Yes ☐ No Pneumonia? ☐ Yes ☐ NoCoughing blood? ☐ Yes ☐ No Tuberculosis? ☐ Yes ☐ NoWheezing? ☐ Yes ☐ No Snoring? ☐ Yes ☐ No**Heart:**Shortness of breath? ☐ Yes ☐ No Rheumatic fever? ☐ Yes ☐ NoChest pain? ☐ Yes ☐ No Swelling of legs? ☐ Yes ☐ NoPalpitations of the heart? ☐ Yes ☐ No Mitral valve prolapse? ☐ Yes ☐ NoAwake from sleep with shortness of breath? ☐ Yes ☐ No**INTESTINAL FUNCTION:**Pain or bleeding with defecation? ☐ Yes ☐ No Diarrhea? ☐ Yes ☐ NoThinning of stools? ☐ Yes ☐ No Constipation? ☐ Yes ☐ NoIndigestion/heartburn? ☐ Yes ☐ No Nausea/vomiting? ☐ Yes ☐ NoBloating? ☐ Yes ☐ No**BLADDER FUNCTION:**Pain or bleeding with urination? ☐ Yes ☐ No Involuntary loss of urine? ☐ Yes ☐ NoEmpty bladder incompletely? ☐ Yes ☐ No Pressure on bladder? ☐ Yes ☐ NoANY SKIN LESIONS OR DISEASE? ☐ Yes ☐ No**NEUROLOGIC:**Seizures? ☐ Yes ☐ No Loss of consciousness? ☐ Yes ☐ NoNerve loss or injury? ☐ Yes ☐ No Stroke or "mini" stroke ? ☐ Yes ☐ No**GENERAL MEDICAL:**

Weight now: _____ Weight 6 months ago: _____

Any psychiatric illness? ☐ Yes ☐ No Any visual problems? ☐ Yes ☐ NoAny hearing problems? ☐ Yes ☐ No Any muscular or skeletal disorders? ☐ Yes ☐ NoAny fever, chills, night sweats? ☐ Yes ☐ No**NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**