



Date: _____

General Information:

Name: _____ Age: _____ Who referred you to us? _____

Who is your primary care physician? _____ Who is your gynecologist? _____

What is the primary reason for your visit? _____

Do you require antibiotics before dental procedures? YES NO

Have you had a blood transfusion? YES NO

Past Medical History:

Please check any problems below that you have had, or are currently experiencing:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acid Reflux / Heartburn | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Exposure to HIV/AIDS | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lung Disease (COPD) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolus | |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Raynauds | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seasonal Allergies | |

Other: _____

Past Surgical History:

Please check all previous surgeries you have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal Hysterectomy | <input type="checkbox"/> Gall Bladder Surgery | <input type="checkbox"/> Paravaginal Repair |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Heart By-Pass Surgery | <input type="checkbox"/> Rectocele Repair |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Removal of Ovaries |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart By-Pass Surgery | <input type="checkbox"/> Sling Procedure |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsilectomy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Tummy Tuck |
| <input type="checkbox"/> Cystocele Repair | <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> Vaginal Hysterectomy |

Other: _____

Current Medications:

Please list all medications you are currently taking:

Allergies:

Please list any allergies you have:

Medication Allergies:

Food Allergies:

Environmental Allergies:

Family Medical History:

Please check any conditions that are prevalent in your immediate family:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Gynecologic Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Attack | |

Other: _____

Reproductive History:

Approximate date of last Menstrual Period: _____

- | | | |
|--|------------------------------|-----------------------------|
| Do you have any abnormal vaginal bleeding? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have pain with menstrual periods? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you sexually active? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you take birth control pills? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Total Number of Pregnancies: _____ Number of Vaginal Deliveries: _____ Number of C-Sections _____

Did you experience any of these problems with vaginal deliveries?

- | | | | |
|----------------------------------|---------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Breech | <input type="checkbox"/> Tears | <input type="checkbox"/> Episiotomies |
|----------------------------------|---------------------------------|--------------------------------|---------------------------------------|

Last Pap Smear was: Normal Abnormal (Date / Details) _____Last Mammogram was: Normal Abnormal (Date / Details) _____**Social History:**

Please check all that apply to you:

Alcohol

- Currently Use
 Never Use
 Previously Used

Cigarettes

- Currently Use
 Never Use
 Previously Used

Illicit Drugs

- Currently Use
 Never Use
 Previously Used

Marital Status: Married Single Widowed Divorced

REVIEW OF SYSTEMS

Please review each of the following boxes and check all that apply to you. If you are not suffering from any of the listed items in the box please check the "NONE" box.

Constitutional:

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Malaise | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Body Aches | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> NONE | | |

Eyes:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Discharge from Eye | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Wear Glasses / Contacts | |

Head, Ears, Nose, Throat:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dentures | <input type="checkbox"/> Discharge from Ear |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Recent Head Injury | <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Oral Ulcers |
| <input type="checkbox"/> NONE | | |

Breasts:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Swelling | <input type="checkbox"/> Abnormal changes in breast size |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> NONE |

Cardiovascular:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Lower Extremity Swelling | <input type="checkbox"/> Pain in Legs with Exercise |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Shortness of Breath with Activity | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> NONE | | |

Respiratory:

- | | | |
|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Spitting Up Blood |
| <input type="checkbox"/> NONE | | |

Gastrointestinal:

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive Flatulence |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Reflux | <input type="checkbox"/> Trouble / Painful Swallowing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Laxative Use |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Leak Stool |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> NONE |

Genitourinary:

- | | | |
|--|--|--|
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Irregular Menses | <input type="checkbox"/> Pain with Sex |
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Difficulty Voiding | <input type="checkbox"/> Pain with Urination |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Heavy Menstrual Cycle | <input type="checkbox"/> Incomplete Bladder Emptying |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Decreased Sex Drive |
| <input type="checkbox"/> NONE | | |

Integument (Skin):

- | | | |
|---|---|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Skin Dryness | <input type="checkbox"/> New Skin Lesions |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hair Growth Change | <input type="checkbox"/> Changes to Existing Lesions / Moles |
| <input type="checkbox"/> Pigmentation Changes | <input type="checkbox"/> Nail Changes | <input type="checkbox"/> NONE |

Neurologic:

- | | | |
|---|--|--|
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tingling or Numbness | <input type="checkbox"/> Seizures | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Tremors | |

Musculoskeletal:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limitation of Motion | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Cramps | |

Endocrine:

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> NONE |

Psychiatric:

- | | | |
|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Feeling Confused | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty Sleeping | |

Heme-Lymph:

- | | | |
|--|--|---|
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Lymph node enlargement or tenderness |
| <input type="checkbox"/> NONE | | |

Allergic-Immunologic:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sinus Allergy Symptoms | <input type="checkbox"/> Frequent Illness | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> NONE | | |