



# PATIENT MEDICAL HISTORY FORM

## Gyn History (continued)

Have you ever had any of the following STD's?

- |                                    |                                      |                                      |  |
|------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HPV         | <input type="checkbox"/> HIV         | <input type="checkbox"/> Never had any |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Syphilis    | <input type="checkbox"/> Hepatitis B |  |
| <input type="checkbox"/> Herpes    | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Hepatitis C |  |

Have you ever had any of the following?     Fibrocystic Breast     Endometriosis     Ovarian Cysts     Uterine fibroids

Date of last pap smear: \_\_\_\_\_  Normal     Abnormal

Have you ever had any of the following for an abnormal pap?     Colposcopy     LEEP/Laser/Conization     Cryo surgery     No

Date of last Mammogram: \_\_\_\_\_  Normal     Abnormal     Never had one

Date of last bone density: \_\_\_\_\_  Normal     Osteopenia     Osteoporosis     Never had one

## Family History – Please list any close relatives with a history of the following:

	Relative		Relative
<input type="checkbox"/> Breast cancer		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Ovarian cancer		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Uterine cancer		<input type="checkbox"/> Heart disease (heart attack, stroke, bypass surgery)	
<input type="checkbox"/> Colon Cancer			

## Social History

- |                 |  |  |
|-----------------|--|--|
| Alcohol use     | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, _____ drink(s) per day / week / month  |
| Tobacco use     | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, _____ pack(s) per day for _____ years  |
| Street drug use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type and frequency _____   |
| Exercise        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type and frequency _____   |
| Caffeine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, _____ caffeinated drinks (coffee, tea, soda) per day / week  |
| Sexual abuse    | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> Yes <input type="checkbox"/> No    Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical abuse  | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> Yes <input type="checkbox"/> No    Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emotional abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> Yes <input type="checkbox"/> No    Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No |

## Review of Systems – Do you currently have any of the following?

- |  |  |
|--|--|
| <p style="text-align: center;"><b>Comments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Generally healthy</li> <li><input type="checkbox"/> Recent weight gain or loss of 25 lbs.</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Vision problems (excluding glasses)</li> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Chronic cough</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Blood in stools</li> <li><input type="checkbox"/> Heartburn / reflux</li> <li><input type="checkbox"/> None of the above</li> </ul> | <p style="text-align: center;"><b>Comments:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Burning with urination</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Urgency</li> <li><input type="checkbox"/> Bladder infection</li> <li><input type="checkbox"/> Stomach pains</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Irregular vaginal bleeding</li> <li><input type="checkbox"/> Pelvic pain</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Breast lumps</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Joint / muscle pain</li> <li><input type="checkbox"/> Depression / anxiety</li> <li><input type="checkbox"/> None of the above</li> </ul> |
|--|--|

## Any further health information we should know.

---



---



---

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

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

Clinician Signature: \_\_\_\_\_

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

Annual Review #2 Clinician Signature: \_\_\_\_\_

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

Annual Review #3 Clinician Signature: \_\_\_\_\_

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