

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of the form as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

Name: _____

Today's Date: _____

Birthdate: _____

PCP: _____

Name of any other providers we should send our note to: _____

What gynecologic issues would you like to discuss today?

Menstrual and Sexual History

How old were you when you had your first period? _____

Are you having periods? If no, skip this section:

Having Periods: What date was the first day of your most recent (*last*) period? _____

Are your periods regular? Yes No

How many days are there between your periods? (*Ex. 28 days*)? _____

How many days does your period last (*how many days do you bleed?*) (*Ex. 5 days*) _____

How are your cramps? Mild Moderate Severe

How heavy is your flow? Light Moderate Heavy

Do you get spotting between your periods? Yes No

No Periods: When did you stop having periods (*age or what year?*) _____

Why are you not having periods? Breastfeeding IUD Hormone pills/shots/implants; Menopause
 Surgery Don't know

Have you ever taken menopausal hormone therapy? Yes No Not applicable

Gender Identity, Sexual Orientation, and Sexual Activity:

What is your gender identity: Female Male Trans Other _____

Are you sexually active? Yes No Not currently

If yes, are your partners Female Male Both

What do you use or do to prevent pregnancy? _____

Would you like to be tested for sexually transmitted diseases today? Yes No

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Routine Health Care

Date of your last Pap test (*if >21 y.o.*): _____ Result: Normal Abnormal

Date of your last mammogram: _____ Result: Normal Abnormal

Date of your last colon cancer screening test: _____ Result: Normal Abnormal

Date of your last cholesterol blood test: _____ Result: _____

Have you had a bone density test? Yes No

Result: _____

Symptom Review

For each item below, please show whether you have had any recent problems by checking yes or no:

<u>General</u>	YES	NO	<u>Lungs</u>	YES	NO
Unusual fatigue	_____	_____	Shortness of breath	_____	_____
Weight gain without trying	_____	_____	Cough	_____	_____
Weight loss without trying	_____	_____	Wheezing	_____	_____
Fevers	_____	_____	Apnea	_____	_____
<u>Eyes</u>			<u>Breast</u>		
Changes in vision	_____	_____	Breast mass	_____	_____
Eye pain	_____	_____	Nipple discharge	_____	_____
			Breast pain	_____	_____
<u>Head/Ears/Throat</u>			<u>Gastrointestinal</u>		
Ringing in ears	_____	_____	Abdominal pain/bloating	_____	_____
Hearing loss	_____	_____	Constipation	_____	_____
Sinus problems	_____	_____	Diarrhea	_____	_____
Sore throat	_____	_____	Acid reflux/heartburn	_____	_____
Hoarse voice	_____	_____	Blood in stool	_____	_____
			Poor control of stool	_____	_____
<u>Heart</u>			<u>Gynecologic</u>	YES	NO
Chest pain	_____	_____	Vaginal discharge	_____	_____
Palpitations	_____	_____	Abnormal vaginal bleeding	_____	_____
			Pelvic pain	_____	_____
			Pain with intercourse	_____	_____
			Premenstrual dysphoric disorder	_____	_____
			PMS	_____	_____

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Urinary **YES** **NO**
 Painful urination ___ ___
 Blood in urine ___ ___
 Poor control of urine ___ ___
 Difficulty emptying bladder ___ ___

Blood/Lymph **YES** **NO**
 Easy bruising/bleeding ___ ___
 Swollen lymph nodes ___ ___

Joints/Bones/Muscles
 Joint pain ___ ___
 Muscle or bone pain ___ ___

Psychiatric
 Anxiety ___ ___
 Depression ___ ___

Skin
 Rash ___ ___
 Changing mole(s) ___ ___

Glands/Endocrine
 Thirsty all the time ___ ___
 Can't stand the heat or cold ___ ___
 Hot flashes ___ ___
 Abnormal hair growth ___ ___

Neurologic **YES** **NO**
 Headaches ___ ___
 Loss of memory ___ ___
 Weakness in limbs ___ ___

Do you have any other concerns that your provider should know about today? __Yes __No
 Explain: _____

Allergies

Please list all allergies that you have (medications, food, etc.) and what reaction occurred:

No Allergies

Medication or Substance	Reaction

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Please list all medications you take, including vitamins, herbal or natural supplements, and prescription as well as over-the-counter medications, whether taken regularly or as-needed:

 No Medications

Medication Name	Dosage

Social History & Habits

<p>Smoking (mark one): <input type="checkbox"/> I have never smoked <input type="checkbox"/> I'm a former smoker <input type="checkbox"/> I'm a current smoker If you used to smoke, when did you quit? _____ If you smoke now, how many years have you smoked? _____ Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No How many packs per day do you smoke? ¼ ½ 1 1½ 2 3 Other: _____</p>
<p>Smokeless tobacco (mark one): <input type="checkbox"/> I have never used <input type="checkbox"/> I'm a former user <input type="checkbox"/> I'm a current user</p>
<p>Do you drink alcohol? (mark one): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many drinks per week? <input type="checkbox"/> Glasses of wine <input type="checkbox"/> Cans of beer <input type="checkbox"/> Shots of liquor</p>
<p>Do you use drugs? (mark one): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I used to in the past, but don't any longer If yes, how many times per week? _____ Which drugs do you use? Marijuana _____ Other : _____</p>
<p>Have you ever been sexually, physically or emotionally abused? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you interested in counseling for any of the above? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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Medical History

Please circle all of the following that you have had:

Abnormal Pap smear	COPD (<i>emphysema</i>)	Genital Warts	Pelvic Pain
Abnormal uterine bleeding	Coronary or Heart Disease	GERD (<i>acid reflux</i>)	PID (<i>pelvic infection</i>)
Anemia	Deep vein thrombosis	Hepatitis	Pulmonary embolism
Anxiety	Depression	HIV	Seizures
Arthritis	Diabetes Type 2 (<i>circle</i>) Diet, pills, insulin	Hypertension	Sexually transmitted infection: (<i>circle below</i>) chlamydia, gonorrhea, trichomonas
Asthma	Diabetes Type 1	Infertility	Stroke
Blood Transfusion	Fibroids	Kidney Disease	Substance Abuse
Cancer (explain below)	Endometriosis	Lipid or cholesterol high	Thyroid disease
CHF (heart failure)	Fibroids	Migraine	Urinary incontinence
Clotting disorder	Genital Herpes	Osteoporosis	Urinary Tract infection

Other medical conditions, or additional information about conditions above:

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Surgical History

Please circle all of the following that you have had:

	Date		Date		Date
Abdomen surgery- Open		Cosmetic surgery		Induced Abortion	
Appendectomy		D&C		Myomectomy (removal of fibroids)	
Bladder suspension		Endometrial ablation		Ovary Removal	
Breast surgery		Gallbladder removal		Pelvic laparoscopy	
C-section		Hernia Repair		Tonsillectomy	
Cervical dysplasia treatment: (circle) freezing, LEEP, Cone, Laser		Hysterectomy: (circle) -Abdominal -Laparoscopic -Robotic -Vaginal		Tubal ligation	
Colon surgery		Hysteroscopy			

Other surgeries and procedures, or additional information about those circled above:

Family History

Were you adopted? Yes No

Has anyone in your biological family had the following:

	✓	Who? Ex. Mother, Maternal Aunt	Age		✓	Who? Ex. Mother, Maternal Aunt	Age
Birth Defects / Twins							
Bleeding Disorder				Diabetes			
Blood Clots (<i>leg, lung, etc</i>)				Endometriosis Fibroids			
Breast Cancer				Heart disease			
Colon Cancer				High cholesterol			
Ovarian Cancer				Thyroid Disease			
Prostate Cancer				Osteoporosis			
Other Cancer:							
Other:							

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Pregnancies and Deliveries

Have you ever been pregnant? Yes No *If no, skip section*

Total Pregnancies: _____ # of living children: _____

Please list all of your pregnancies in the table below including all miscarriages, ectopics and abortions.

Date of Delivery / Ectopic / Miscarriage	Gestational Age (in wks)	Outcome (Vaginal birth / cesarean / ectopic / miscarriage / etc.)	Weight	Gender	Hospital	Complications?
<i>Example: 4/2/96</i>	<i>38 weeks</i>	<i>Cesarean</i>	<i>6lbs 4oz</i>	<i>Boy</i>	<i>UWMC</i>	<i>No</i>

Immunizations

Vaccine for:	Have you ever had this vaccine?	If yes, date(s):
HPV or Human papillomavirus (Gardasil or Cervarix)	Yes No Don't know	1. _____ 2. _____ 3. _____
Hepatitis B vaccine (HBV)	Yes No Don't know	1. _____ 2. _____ 3. _____
Influenza vaccine (Flu shot)	Yes No Don't know	Last dose: _____
Measles, mumps, & rubella (MMR)	Yes No Don't know	Last dose: _____
Tetanus/diphtheria (Td)	Yes No Don't know	Last dose: _____

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PHQ2:

Over the past 2 weeks, how often have you been bothered by the following problems?

<i>Circle <u>one</u> number in each line</i>	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Safety and Work/Life

Do you exercise? Yes No How many hours per week? _____

When biking, do you wear a helmet? Yes No

When driving, do you wear a seatbelt? Yes No

Where and with whom do you live? _____

Do you have trouble taking care of your daily activities? (Ex. Buying food) Yes No

Do you feel safe in your current living situation? Yes N

How often does your partner or boss: (Circle one number in each line)

	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically hurt you	1	2	3	4	5
Insult or talk down to you	1	2	3	4	5
Threaten you with harm	1	2	3	4	5
Scream or curse at you	1	2	3	4	5

Total: _____

What is your profession / occupation? _____

For how long? _____

Were you forced into your line of work? Yes No

Is someone telling you that you owe them money and is using that to control you? Yes No

PATIENT SIGNATURE	PRINT NAME	DATE	
SUBMITTING STAFF SIGNATURE	PRINT NAME	DATE	TIME

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