Medical History

G___P___ A___
(Office Use)

Patient Name____ **Date of Birth**______________ **Date**_________________

Reason for today's visit: ☐Annual ☐Follow-Up ☐Problem________________ ☐Other__________________

Brief description of problem or other concern: ____

Personal Health History:

When was the first day of your last menstrual period? _____________ Was your last period normal? ☐Yes ☐No
How frequently does your period occur? __________________How many days does your period last? _________
Do you experience irregular or inconsistent bleeding patterns? ☐Yes ☐No ☐Sometimes
Current method of birth control? ____
Would you like information on a simple, safe procedure performed in our office that can reduce or eliminate your monthly periods? ☐Yes ☐No Is your family complete? ☐Yes ☐No
Would you like information on a gentle hormone free permanent procedure? ☐Yes ☐No
Do you have any problems/concerns with leaking urine, frequency or painful urination? ☐Yes ☐No

Please check all that apply to yourself:

☐Breast Cancer ☐Uterine Cancer ☐Colon Cancer ☐Ovarian Cancer
☐Cervical Cancer ☐Other Cancer (list below) ☐Thyroid Issues ☐Diabetes
☐High Blood Pressure ☐High Cholesterol ☐Abnormal Pap Smear ☐Treatment of Abn. Pap
☐Other diseases not mentioned____

Please list All Surgeries: ____
____
____

Social History:

Occupation: ____Marital Status_______________
Is violence at home a concern for you? ☐Yes ☐No Have you ever been abused? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No; If yes, how many packs per day? ______________________
Do you drink alcohol? ☐Yes ☐No; If yes how many drinks per week? ____________________
Do you use drugs? ☐Yes ☐No; If yes, what type? ____________________________________
Are you sexually active? ☐Yes ☐No ☐Not currently ☐ Have Never been sexually active
Have you had four or more sexual partners? ☐Yes ☐No
Have you had any sexually transmitted diseases? ☐Yes ☐No
Have you had a weight change in the last year? ☐Yes ☐No; If yes, ☐Gain ☐ Loss How many pounds? ______
Do you exercise 3 or more times a week? ☐Yes ☐No

Please List Current Medications and Herbal Supplements: ____
____
____

Please List Allergies: (Medication and Food) ____
____
____

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Name____ **Date of Birth**______________ **Date**______________

Review of Symptoms: **Please check any current problems you have on the list below**:

General	**Skin**	**Gastrointestinal**	**Neurological**	**Hematology**
☐Chills ☐Fever ☐Fatigue ☐Weight Loss ☐No Problem	☐Rash ☐Sweaty ☐Itchy ☐Acne ☐ No Problem	☐Abdominal Pain ☐Constipation ☐Diarrhea ☐Nausea ☐Vomiting ☐ No Problem	☐Seizures ☐Dizziness ☐Syncope ☐Weakness ☐Numbness ☐ No Problem	☐Easy Bleeding ☐Easy Bruising ☐ No Problem
Ear/Nose/Throat	**Endocrine**	**Cardiac**	**Psychiatric**	**Respiratory**
☐Hearing Loss ☐Nosebleeds ☐Sore Throat ☐Rhinitis ☐ No Problem	☐Heat/Cold Intolerance ☐Excessive Thirst ☐ No Problem	☐Chest Pain ☐Palpitation ☐ No Problem	☐Depression ☐Anxiety ☐ No Problem	☐Cough ☐Shortness Of Breath ☐ No Problem
Eyes	**Urinary**			
☐Blurred Vision ☐Light Sensitivity ☐ No Problem	☐Painful Urination ☐Discharge ☐Bloody Urine	☐Incontinence ☐Flank Pain ☐Weak Stream	☐Incomplete Voiding ☐Frequent Urination ☐Straining	☐Hesitancy ☐Urgency ☐ No Problem

Please check any symptoms you are experiencing and the frequency or severity of the symptoms:

Night Sweats	☐Never	☐1-3 Times/Week	☐Nightly
Sleeping Problems	☐Never	☐1-3 Times/Week	☐Nightly
Hot Flushes	☐Never	☐1-3 Times/Week	☐Nightly
Sexual Desire	☐Not a Problem	☐Decreased	☐No Desire
Pain with Intercourse	☐Never	☐Occasionally	☐Almost Always
Vaginal Dryness	☐Never	☐Occasionally	☐Almost Always
Urine Leakage	☐Never	☐Occasionally	☐Always
Difficulty Concentrating	☐Not a Problem	☐Getting Worse	☐Almost Always
Memory Loss	☐Not a Problem	☐Getting Worse	☐Almost Always
Foggy Thinking	☐Not a Problem	☐Getting Worse	☐Almost Always
Mood Swings	☐Rarely	☐Occasionally	☐Frequently
Depression	☐Rarely	☐Occasionally	☐Frequently
Anxiety	☐Rarely	☐Occasionally	☐Frequently
Headaches	☐Never	☐1-3 Times/Month	☐Weekly
Muscle Pain	☐Never	☐1-3 Times/Month	☐Weekly
Joint Pain	☐Never	☐1-3 Times/Month	☐Weekly
Breast Pain/Lump	☐Never	☐1-3 Times/Month	☐Weekly

Are you taking medication or herbal supplements for any of the above symptoms? ☐YES ☐NO