Taylor Associates

O b s t e t r i c s & G y n e c o l o g y

PERSONAL MEDICAL HISTORY

This is a confidential record of your medical history. Information you provide here will not be given to any other person unless you authorize us to do so.

Name _______________________________ Date of Birth ____/____/____

Other names you have gone by, including maiden or nickname: ______________________________________

Primary Care Physician ____________________ Other Health Care Providers ___________________________

____

MENSTRUAL HISTORY

Age at first period ___***Have you had periods or any vaginal bleeding (in the past 12 months)? Yes No***

**** If no, proceed to next section****

How long ago was the 1st day of your last period? (date)____/___/_________

Periods now: regular ____ irregular ____ absent ____; # of tampons and/or pads used on heaviest day?_____

Periods occur every ____ days (from start of 1 period to start of next) and last for ___ days.

Do you have cramps with your period? Yes No Do you take medication for cramps? Yes No

If yes, what (include dose per day)? ____

On what day of your cycle do they start? ________________How long do they last? _____________

Do you ever miss school or work during your period? Yes No If yes, why? ___________________

Do you ever bleed in between periods? Yes No Please describe:___________________________________

Have you ever missed periods for 3 months or longer (except for pregnancy)? Yes No

Describe ____

Before your period (premenstrual) do you get any of the following symptoms? (Circle all that apply)

Bloating Breast tenderness Cramps Leg aches Irritability

Food cravings Fatigue Depression Anger Hot flashes or night sweats

****If you no longer have periods, or have irregular periods, please answer the following questions:***

Are you taking or have you ever taken hormone replacement or any hormonal regimen to regulate your periods, improve discomfort, or to decrease heavy vaginal bleeding? Yes No

For how long? ____ What hormones? _____________________________

Have you ever had any vaginal bleeding since going 1 year without a period? Yes No

Describe ____

Do you have any hot flashes or night sweats? Yes No If so are they (circle): mild moderate severe

Do you have problems with vaginal dryness? Yes No Do you use any lubricants? Yes No

Which ones? _________________________

CONTRACEPTIVE (BIRTH CONTROL) HISTORY

Current contraceptive method is: ____________________ None Not applicable

Which of the following methods have you ever used & indicate when you used it:

Pills ____ Depo Provera ____ Patch ____ Implanon____ Mirena IUD____ Nuvaring___

Paraguard IUD ____ Condom ____ Diaphragm ____ Cervical cap ____

Spermacides (foam, sponge, film, etc.)____ Withdrawal ____ Rhythm____

Vasectomy ____ Tubal ligation____ Tubal occlusion device (Essure or Adiana)____

Did you have any problems with any of these methods? Yes No

If Yes, please describe: ____

____

PREGNANCY PLANNING & OBSTETRICAL HISTORY

Have you ever been pregnant? Yes No ***If no, skip to the next * question.***

Age at first pregnancy? ______ List in order your **pregnancies** including miscarriages, abortions, ectopics.

Month/Year	Vag or C/S	Sex	Wt	Name	Complications /Problems

****Do you want to have children in the future?*** Yes No *If Yes, we encourage you to schedule a **pre-conception visit**.*

Have you ever had a problem getting pregnant? Yes No

If yes, have you ever had an evaluation by a doctor for infertility? Yes No

*If no, we encourage you to schedule an **infertility discussion visit**.*

Please describe any infertility evaluation or treatment that you or your partner have had:

____

SEXUAL HISTORY

Have you ever been sexually active? Yes No If yes, how old were you when you first had intercourse? ____

Are you currently sexually active (in the past 12 months)? Yes No

Are your past or current sex partners: Male ____ Female ____ Both ____

Number of partners in the last year: ____ Ever ____ Sexual contact: oral ____ anal ____ vaginal ____

If you have a steady partner, for how long have you been together?____years

Do you have any pain or bleeding with sexual activity? Yes No If yes, explain:_______________________

Have you ever had any of the following infections (circle all that apply)?

Herpes Gonorrhea Chlamydia Genital Warts/HPV condyloma Syphilis

HIV (AIDS) Trichomonas Yeast vaginitis Bacterial vaginitis

Pelvic Inflammatory Disease (Infection in fallopian tubes /and or ovaries)

Uterine infection (such as that after a delivery or uterine procedure)

Do you have any vaginal concerns today? Yes No **If yes, indicate which of the following (circle all that apply):**

Discharge Odor Itching Other: ___________

Do you have any sexual concerns that you would like to discuss? Yes No If yes, explain:_________________

____

URINARY TRACT HISTORY

Do you have burning and/or pain when passing urine? Yes No

Do you pass urine more often than 8 times a day? Yes No

Do you feel that your bladder does not empty entirely? Yes No

Do you have to change positions or “bear down” to empty? Yes No

Do you have difficulty holding your urine? Yes No

Do you lose urine when you cough, sneeze, laugh, exercise, etc? Yes No

Do you lose urine without warning? Yes No

Do you wake up at night to urinate? Yes No How often? ___

Do you wear pads because of urine leakage? Yes No

Do you ever feel an uncomfortable vaginal pressure or a bulge? Yes No

If you answered yes to the above questions: Please elaborate on your symptoms and treatments:____

____

COLON & RECTAL HISTORY

Have you had problems with hemorrhoids or rectal fissures? Yes No

Do you have to change position or other maneuvers to feel fully emptied of stool? Yes No

Do you have problems with frequent flatus? Yes No Do you have problems with stool incontinence? Yes No

Have you seen any blood in your stool? Yes No Do you have frequent constipation? Yes No

Do you have frequent loose stools? Yes No

If yes to any of the questions in this section, please elaborate:____

____

OTHER MEDICAL HISTORY

List all hospitalizations and surgeries below:

Month/Year	Remarks	Doctor	Month/Year	Remarks	Doctor

List all Current Medical Problems: ____

____

____

____

PREVENTATIVE CARE AND CANCER SCREENING

Date of last **pap/pelvic exam:** ____________

Any history of **abnormal pap?** Yes No

If yes, what was the diagnosis and treatment? _____________________________________

Do you do self breast exams? Yes No Have you had any breast lumps or discharge? Yes No

Have you ever had any breast imaging, such as ultrasound or mammogram? Yes No

Date of last **mammogram** __________ Was it: Normal Abnormal

Did you have any additional tests? Yes No

If yes, what were the results and what was the treatment plan?______________________

____

Have you ever had a **bone density test**? Yes No When? ______ Results? Normal Osteopenia Osteoporosis

Have you ever taken medications for prevention or treatment? Yes No Which one(s)?________How long?____

Have you ever had a **colonoscopy**? Yes No If yes, when _______ Was it normal? Yes No _________________

In what time interval were you told to have the next colonoscopy? ______________________________

Are you **immunized** for: (*circle one)*

Measles/Mumps/Rubella	Yes	No	Don't know	
Polio	Yes	No	Don't know	
Varicella (chicken pox)	Yes	No	Don't know	
Tetanus w/Pertussis (Tdap)	Yes	No	Don't know	*Note: this vaccine became available in 2005*
Hepatitis B	Yes	No	Don't know	
HPV (Gardasil)	Yes	No	Don't know	
Seasonal Flu	Yes	No	Don't know	*Last seasonal flu immunization was:*________
Pneumovax	Yes	No	Don't know	

Does your PCP have your immunization records? Yes No

If no, do you have it? Yes No ***(If yes, bring to your next appointment here for us to review)***

ALLERGIES

List any drug/chemical/ or food allergies and specify type of reaction:

____

Latex allergy? Yes No **Tape allergy? Yes No** **IV contrast/iodine/betadine allergy? Yes No**

MEDICATIONS

List all medications (prescriptions/non-prescription) including vitamin &, supplements. Please also note the dose and frequency:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Any others:____

SOCIAL & SAFETY HISTORY

Please indicate your **marital status**: Single Married Widowed Divorced Legal Union

Occupation _______________________ Any **occupational exposures**? Yes No If yes, what?______________

Do you use **seat belts** most of the time? Yes No Do you use **sun screen** most of the time? Yes No

Do you **exercise** regularly? Yes No If yes, how many times per week? _________________________

What kind of exercise do you do and for how long?_____________________________________

____

Have you **smoked** cigarettes? Yes No Quit date/year ________

Are you currently smoking? Yes No How many **packs per day**?____

How many years have you been smoking or did you previously smoke?_____

How many cups of coffee, tea or other beverages containing **caffeine** do you drink daily? ____

How many **alcoholic beverages** do you drink in one sitting? ___ How many times a week? ___ What kind?__________

Do you have a history of problems with alcohol? Yes No

Have you ever and do you now use any **street drugs?** ___ by mouth ___ injection ___ Inhale ___

What kind?:____

Have you ever sought help for alcohol or street drug use, including prescription drugs? Yes No

If yes, when?____

Have you ever been hit, kicked, or **injured** repeatedly in other ways? Yes No

Have you ever been forced against your will to have sex or perform any sexual acts? Yes No

If yes to either of the past 2 questions, please explain:______________________________

Do you want to discuss your safety with your clinician? Yes No

Do you have a religious or **spiritual belief**? Yes No If yes, what?______________________________

Who would you **rely on to assist** you with any emotional or physical needs?_________________________

Do you have any current financial stressors that you fear may limit your ability to obtain healthcare? Yes No

Any other sources of **stress** that you would like to inform us about? _____________________________________

PERSONAL AND FAMILY CANCER HISTORY

If cancer in your family, ask us about screening for a genetic predisposition.

*Please indicate which cancers **you** and your blood-related family members have had **(parents, grandparents, aunts, uncles, siblings, and children).***

	Self: Age diagnosed	**Relative: Age Diagnosed & If died from cancer, age of death**
Breast Cancer:	____________________	____________________
Colon Cancer or Polyps	____________________	____________________
Ovarian Cancer:	____________________	____________________
Prostate Cancer:		____________________
Skin Cancer:	____________________	____________________
Uterine Cancer:	____________________	____________________
Other Cancer Type:	____________________	__________ ***Are you Ashkanazii Jewish? Yes No***

ADDITIONAL FAMILY HISTORY

Are you adopted? Yes ___No ____ *If yes, do you know your birth's family medical history? Yes No*

***If no, skip this section.**

Indicate who of your blood relatives have or had any of the following problems. Circle all that apply.

Diabetes:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
High blood pressure:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Stroke:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Heart attack/Cor.Artery Ds	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Bleeding disorder:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Blood clots in legs or lungs:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
High Cholesterol:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Arthritis:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Osteoporosis:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Depression/mental Illness:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Alzheimer's disease/dementia	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Other Inheritable diseases	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C
Physical Problems at Birth:	F	M	MGM	MGF	PGM	PGF	MatA	PatA	MatU	PatU	B	S	C

F – Father **M**- Mother **MGM/MGF** – maternal grandparents **PGM/PGF** – paternal grandparents
A - Aunt/name **U** – Uncle/name (**MAT maternal/ PAT paternal**) **B** – brother/name **S** – Sister/name **C** - Child/Name

Provide Details of any of the above + responses, including Name, Age Diagnosed, and if applicable, age of Death:____

____

____

Did your mother take DES when she was pregnant with you? Yes No Don't Know

Any additional Family History?____

REVIEW OF SYSTEMS

Please circle any of the following conditions that you have had:

1. Skin problems
2. High Blood Pressure
3. Heart Disease/Angina
4. Rheumatic fever
5. High cholesterol
6. Stroke/TIA (Pre-stroke)
7. Clots in legs or lungs
8. Anemia
9. History of Blood transfusions
10. Shortness of breath
11. Lung problems/pneumonia
12. Asthma
13. Sleep apnea
14. Problems with balance
15. Frequent headaches
16. Diagnosed migraines
17. Epilepsy/convulsions
18. Anorexia Nervosa/Bulimia
19. Depression
20. Anxiety
21. Thyroid disease
22. Diabetes
23. Back problems
24. Arthritis
25. Bladder or Kidney problems
26. Gallbladder disease
27. Stomach/intestinal problems
28. Jaundice (yellow skin/eyes)
29. Other:__________________

____

For all positive answers give #, dates, and details of any on-going treatment. Use back of page if necessary:

____

<u>If you needed a blood transfusion to save your life, would you accept it?</u> Yes No

If no, why not? (circle) Religious beliefs Other reason (specify):

PLEASE READ AND SIGN: I acknowledge that the above information is correct and complete.

______________________________________ ______________________

Patient's Signature **Today's date**

______________________________________ ______________________

Reviewer **Date reviewed**

Rev 5/13/11 UAS<T for Taylor Associates, A division of Physicians for Women's Health