CENTER FOR
ADVANCED GYNECOLOGY

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MEDICAL HISTORY INTAKE

Today's Date: ____/____/___ Name: ___________________________________ Date of Birth:___/____/_____
What brings you to our office today:____
____
____

PERSONAL PROFILE

Marital Status: __________________ Number of people in household: _______
Highest Education level completed: grade school high school college graduate degree other
Current Job/work: ____________________________________
Place of work: _______________________________________

Please list all ACTIVE treating physicians (i.e. ob/gyn, oncologist, internist, cardiologist, etc…)
Doctor's Name: ____________________________________ Specialty:_____________________________
Doctor's Name: ____________________________________ Specialty:_____________________________
Doctor's Name: ____________________________________ Specialty:_____________________________
Doctor's Name: ____________________________________ Specialty:_____________________________

ALLERGIES

Drug, Environmental, or Food Allergy Reaction

MEDICATIONS & SUPPLEMENTS

Please list ALL medications, including over the counter and prescribed. Please be thorough. Use the back of this sheet for additional space if needed..

Medication Name	Strength	How often taken	Reason for taking

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OBSTETRICAL HISTORY	
# ______ Pregnancy	Were there any complications during pregnancy, labor, delivery, or postpartum?
# ______ Full term (37+ weeks)	(please circle all that apply)
# ______ Premature	C- Section (#______) Vacuum Forceps Episiotomy
# ______ Miscarriage	3rd or 4th degree tear Heavy bleeding after delivery
# ______ Abortion	Other: ____
# ______ Living children	____

GYN HISTORY

How old were you when your menses started? _________

Are you still having menstrual periods? Yes No

Answer the following section only if you are still having menstrual periods.

First day of your last menstrual period? ____/____/____

How many days between your periods? ____________

How many days of menstrual flow? _______________

Periods are: Light Moderate Heavy Bleed through protection

Are your periods regular? Yes No

Do you have any pain with periods? Yes No

If yes, when does pain start? With Start of Flow #____ days before flow

When was your last pap smear/HPV testing? _____/______/______ Was it Normal? Yes No

Have you ever had an abnormal pap? Yes No

If yes, when? _____/______/______ What was the abnormality?_____________________

Have you ever had the following:

☐ Colposcopy - Date:_________ ☐ LEEP - Date: _________

☐ Cryosurgery (Freezing) - Date: ________ ☐ Other - Date: _________

Did you have the full course of HPV Vaccine? Yes No

Do you prefer: men women both neither

Have you ever had: (Please circle all that apply)

trichomonas genital herpes chlamydia gonorrhea pelvic inflammatory disease (PID)

Birth control method:__________________________

If you have had a mammogram, when was the last? ___/___/____ result: normal abnormal

Do you currently or in the past have you had:

Endometriosis Yes No

Fibroids Yes No

Infertility Yes No

Ovarian Cysts Yes No

PCOS Yes No

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FAMILY HISTORY: Please circle those that apply & list family member (e.g. mother)

Breast Cancer	Diabetes	Heart Disease
Chronic Pelvic Pain	Drinking/Drug Problem	Hypertension
Colon Cancer	Embolism	Ovarian Cancer
Depression	Endometrial Cancer	Pulmonary
Deep Venous Thrombosis(DVT)	Endometriosis	Stroke

Other cancer (e.g. prostate)____
Other please specify:____
I AM ADOPTED

HEALTH HABITS
Exercise? Rarely 1-2 times weekly 3-5 times weekly Daily
Caffeine intake (# cups per day, including coffee, tea, soft drinks, etc)? 0 1-3 4-6 >6
Tobacco use: Yes No # packs/day: ____ Age started: _____ Age quit: _____
Alcohol use: Yes No # drinks per week: ____
Have you ever received treatment for substance abuse? Yes No
What is your use of recreational drugs? Never used Past use Presently using
Amphetamines Barbiturates Cocaine Heroin Marijuana Other_______________

PERSONAL SAFETY

Has anyone ever...			
threatened or hurt you?	Y N	forced you to have sex? (this includes your partner)	Y N
hit, kicked, choked, or hurt you physically?	Y N	Are you ever afraid of your partner?	Y N

OPERATIONS / HOSPITALIZATIONS
Year Procedure or Hospitalization Reason (Surgeon)

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PAST MEDICAL HISTORY Please circle all that apply

Alzheimer's/Other Dementia	Crohn's Disease/ Ulcerative Colitis	Irritable Bowel Syndrome
Anemia	Depression	Kidney Disease
Anxiety Disorder	Diabetes	Lung Disease
Arthritis	Digestive Disorders	Memory Loss
Asthma	Epilepsy/ Seizures	Menopause
Back Pain	Eye Disease	Osteoporosis
Blood Pressure, High	Fibromyalgia	Pulmonary Embolism/DVT
Breast Cancer	Headache	Sleep Apnea
Cholesterol, High	HIV/ AIDS	Stroke
Colon Cancer	Insomnia	Thyroid Disorders
Congestive Heart Failure	Interstitial Cystitis	Urine or Bladder Problem

Other Conditions not listed above:

Completed by: ☐ Patient ☐ Nurse ☐ Physician

Signature of Patient ____