NAME: _____

Date of Birth: _____

Date of Visit: _____

MEDICAL HISTORY

Who referred you for Consultation? _____ His / Her Specialty: _____

Referring Dr.'s Address: _____ Phone # ( ) _____

_____

Are there any other physicians (e.g. Primary Care) with whom you would like your consultation discussed?

Dr.'s Name & Address: _____ Specialty: _____

_____ Phone # ( ) _____

For what reason were you referred?

Please Circle any symptoms and check any problems body system problems you have :

Excessive Weight gain or loss Fever/Chills/Night sweats Loss of appetite Fatigue/Malaise

Chest pain /Palpitations Problems with urination Nausea/Vomiting/heartburn/Change in bowel habit

Cough /Shortness of breath/Other Respiratory probs: _____ Allergy or Immune problems: _____

Dizziness/Fainting/Headache/ Other Neurologic probs: _____ Psychological problems: _____

Vaginal bleeding/discharge/Menstrual probs: _____

Problems with: Skin Eyes/Ears/Nose/Throat Blood/Lymph system Muscles Endocrine (glands)
(Explain:) _____

PAST MEDICAL HISTORY Please check any medical problems with which you have ever been diagnosed:

_____ Hypertension (High blood Pressure)

_____ Diabetes

_____ Heart problems

- _____ Coronary Artery Disease /Heart Attack
- _____ Congestive Heart Failure
- _____ Hypercholesterolemia (High Cholesterol)
- _____ Arrhythmia (Irregular hear beat)

_____ Liver problems

- _____ Hepatitis: ___A ___B ___C
- _____ Gall Bladder attacks

_____ Neurologic/Psychiatric problems

- _____ Stroke
- _____ Seizures
- _____ Depression

_____ Stomach problems

- _____ Ulcer
- _____ Acid reflux

_____ Hemophilia or other Bleeding disorder

_____ Phlebitis / Blood clots in deep veins or lung

_____ Lung Problems

- _____ Asthma
- _____ Tuberculosis
- _____ Emphysema

_____ Kidney / Bladder problems:

- _____ Stones
- _____ Infection

_____ Thyroid Problems

- _____ Hypothyroidism (Low Thyroid)
- _____ Hyperthyroidism (Overactive)

_____ Cancer: Type _____

- _____ Received Radiation
- _____ Received Chemotherapy

_____ Other: _____

Have you ever had a flexible sigmoidoscopy or colonoscopy (screening for colon cancer)?_____ When? ____

Any other medical problems, injuries or hospitalizations? _____

List all the Medications you take – including the dose and frequency: _____

_____

_____

Are you allergic to any medications or Latex? _____ If so, what type of reaction? _____

List all of the Surgeries you've had and the dates: _____

_____

_____

_____

OBSTETRIC & GYNECOLOGIC HISTORY

Age at first menstrual period? _____ Are they (or were they) regular or irregular? _____
Date of last period: ____ How long are/were they? _____ How many days between periods? ____

Number of pregnancies: _____ # of births: ____ # of Abortions: _____ # of Miscarriages: _____

Vaginal deliveries: _____ Cesarean Sections: _____ Reason for C-Section: _____

When was your last Pap Smear? _____ Pap before that? _____ Any abnormal Paps? _____

When was your last mammogram? _____ Any abnormal? _____ Any biopsies? _____

Did you ever take the birth control pill? _____ For how many years in total? _____

Ever taken hormone replacement therapy (Estrogen and/or progesterone)? _____ How long? _____

Type of hormone therapy and how taken: _____

Have you ever had sex ? _____ With? (circle) Men / Women / Both Any problems? _____

Are you currently sexually active? _____ Do you have pain with intercourse? _____

Do you use birth control? _____ What method? _____ Have you ever used an IUD? _____

Have you had any gynecologic problems in the past? _____ *(Check all that apply)*

_____ Fibroids _____ Ovarian cysts _____ Endometriosis _____ Infertility _____ PMS

_____ Sexually transmitted diseases (Herpes, HPV, Chlamydia, Gonorrhea, Syphillis, HIV) or PID

_____ Heavy bleeding requiring medication or surgery _____ Pelvic prolapse or urinary problems

FAMILY HISTORY

Does anyone in your family have cancer? (Who & what type) _____

Any other serious medical problems run in your family? (Explain) _____

SOCIAL HISTORY

____ Single ____ Married- how long? ____ _____ Divorced ____ Domestic partnered ____ Widowed

Education level achieved _____ Do you work outside the home? _____ What type of work? _____

Where do you live? _____ Who lives with you at home? _____

On whom do you rely for emotional support or help with decisions? _____ Relationship: _____

Do you smoke? ____ Did you use to smoke? _____ How many packs per day? _____ How long? _____
How much alcohol do you drink? ____ None _____ Minimal _____ Moderate _____ Excessive

Any other information you think may be helpful? (Explain) _____