

Medical History Form

Date _____

First Name _____ Maiden/Middle Name _____ Last Name _____

Date of Birth _____

How did you learn about Brandon Gynecology Associates, PA? _____

Past OB/Gyn History

Last menstrual period _____ Prior menstrual period _____

Regular menses? Yes No Heavy menses? Yes No # of pads _____ # of tampons _____

Painful menses? Mild Moderate Severe

How do you treat menstrual pain? _____

Irregular menses? Please explain _____

Age of first menses _____ Age of first intercourse _____ Age of menopause (no menses for at least one year) _____

Have you ever taken Hormones? Yes No Types _____ Dates _____

How many pregnancies? _____ How many live births? _____ How many miscarriages? _____

How many ectopic pregnancies? _____ Any C-sections? Yes No

How many living children? _____ Ages _____

Did you breast feed for at least 3 months? Yes No

Any complications with pregnancies? If so, explain _____

Are you sexually active? Yes No Do you have sex with Men Women Both

Present birth control method (including vasectomy) _____

Do you have pain with sex? Yes No

Have you ever been abused? Yes No Sexually Physically Psychologically

When did the abuse occur? _____

Are you in a safe situation now? Yes No

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Have you ever had any of the sexually transmitted infections or diseases listed below? If so, please check the diagnosis and provide treatment dates.

- | | |
|--|---|
| <input type="radio"/> Chlamydia _____ | <input type="radio"/> Hepatitis _____ |
| <input type="radio"/> Genital Herpes _____ | <input type="radio"/> Human Papillomavirus (HPV) _____ |
| <input type="radio"/> Genital Warts _____ | <input type="radio"/> Pelvic Inflammatory Disease (PID) _____ |
| <input type="radio"/> Gonorrhea _____ | <input type="radio"/> Syphilis _____ |
| <input type="radio"/> HIV/AIDS _____ | <input type="radio"/> Trichomoniasis _____ |

Have you ever had any of the following gynecological conditions? If so, please check the condition and provide treatment dates.

- | | |
|---|---|
| <input type="radio"/> Abnormal Pap Smears _____ | <input type="radio"/> Fibrocystic Breast Disease _____ |
| <input type="radio"/> Breast Cancer _____ | <input type="radio"/> Infertility _____ |
| <input type="radio"/> Cervical Cancer _____ | <input type="radio"/> Ovarian Cancer _____ |
| <input type="radio"/> Chronic Pelvic Pain _____ | <input type="radio"/> Ovarian Cysts or Tumors _____ |
| <input type="radio"/> Endometrial Polyps _____ | <input type="radio"/> Painful Sex _____ |
| <input type="radio"/> Endometriosis _____ | <input type="radio"/> Uterine Cancer/Endometrial Cancer _____ |
| <input type="radio"/> Fibroids _____ | <input type="radio"/> Vulva Cancer _____ |

Gynecology Surgery

If you have had any of the surgical procedures listed below, please indicate which ones and provide the date of the surgery and any complications that you may have had.

- | | |
|---|---|
| <input type="radio"/> Colposcopy _____ | <input type="radio"/> IUD: Mirena _____ Paraguard _____ |
| <input type="radio"/> Cone biopsy of Cervix _____ | <input type="radio"/> Laparoscopy (surgical exploration of pelvis by camera) _____ |
| <input type="radio"/> Dilatation & Curettage _____
(scraping the lining of the uterus) | <input type="radio"/> LEEP (Electrosurgical biopsy of the cervix) _____ |
| <input type="radio"/> Ectopic (pregnancy in fallopian tubes) _____ | <input type="radio"/> Myomectomy (removal of fibroids) _____ |
| <input type="radio"/> Endometrial Ablation _____ | <input type="radio"/> Oophorectomy (removal of ovaries) _____
____ Right ____ Left ____ Both |
| <input type="radio"/> Essure (sterilization) _____ | <input type="radio"/> Ovarian Cystectomy _____ |
| <input type="radio"/> Gynecological Cancer Surgery _____ | <input type="radio"/> Pelvic Support Surgery _____ |
| <input type="radio"/> Hysterectomy (removal of uterus) _____
<input type="radio"/> Abdominally
<input type="radio"/> Vaginally
<input type="radio"/> Laparoscopic
<input type="radio"/> Robotic | <input type="radio"/> Polypectomy (removal of polyps) _____
____ Cervical ____ Uterine |
| <input type="radio"/> Hysteroscopy _____ | <input type="radio"/> Tubal Ligation (sterilization) _____ |
| <input type="radio"/> Infertility Treatments _____ | <input type="radio"/> Uterine Artery Embolization (treatment for fibroids) _____ |
| | <input type="radio"/> Urinary Incontinence Surgery _____ |
| | <input type="radio"/> Vulva Biopsies _____ |

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Medical Conditions

If you have had any of the following medical conditions, please indicate the diagnosis date and treatment.

Autoimmune

- Lupus _____
- Rheumatoid Arthritis _____

Cardiovascular

- Anemia (Iron Deficient, Sickle Cell, B12 deficiency) _____
Dates of any blood transfusions _____
- Bleeding disorders _____
- Deep Vein Thrombosis/Pulmonary Embolus _____
- Heart Disease _____
- High Blood Pressure _____

Dermatological

- Eczema _____
- Skin Cancer/Melanoma _____
- Lichen Sclerosus/Lichen Planus _____

Endocrine

- Diabetes _____
- Prolactinoma _____
- Thyroid Disease _____

Gastrointestinal

- Colon Cancer _____
- Crohn's Disease _____
- Hiatal Hernia _____
- Inflammatory Bowel Disease _____
- Irritable Bowel Syndrome (IBS) _____
- Liver Disease (Hepatitis) _____
- Peptic Ulcer Disease _____
- Reflux _____

Musculoskeletal

- Arthritis _____
- Ankylosing Spondylitis _____
- Degenerative Joint Disease _____
- Gout _____
- Inflammatory Arthritis _____
- Osteoporosis/Osteopenia _____
- Psoriatic Arthritis _____
- Rheumatoid Arthritis _____

Neurological

- Alzheimer's Disease _____
- Cerebral Palsy _____
- Dementia _____
- Migraine Headaches _____
- Multiple Sclerosis _____
- Muscular Dystrophy _____
- Parkinson's Disease _____
- Seizure Disorder _____
Date of last seizure _____
- Strokes _____

Psychiatric

- Anxiety _____
- Bipolar Disorder _____
- Insomnia _____
- Major Depression _____
- Post Partum Depression _____
- Premenstrual Syndrome/PMDD _____
- Psychiatric Admissions _____
- Substance Abuse _____

continued

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Respiratory

- Asthma _____
- Bronchitis _____
- Sleep Apnea _____

Urological

- Kidney Malformation _____
- Kidney Stones _____
- Recurrent Bladder Infections _____
- Renal Transplant _____
- Nephritis _____
- Polycystic Kidneys _____
- Pyelonephritis (history of kidney infection) _____

Medications

Please list any medication allergies and type of reaction.

Please list all medications (prescribed, over the counter, herbal and natural preparations).

Are you on any blood thinners? Yes No Name of medication _____

Any psychiatric medications? Yes No Name of medication _____

Surgical History

If you have had any of the following surgeries, please indicate dates and complications, if any.

- Appendectomy _____
- Back Surgeries _____
- Breast Reduction or Augmentation _____
- Cholecystectomy (removal of Gallbladder) _____
- Hernia Repair _____
- LASIK Eye Surgery _____
- Plastic/Cosmetic Surgery _____
- Tonsillectomy _____

List any other surgeries with dates and complications.

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Social / Relational History

Do you smoke? Yes No # of packs per week _____ # of years _____

Do you drink alcohol? Yes No # of drinks per week _____

Do you exercise? Yes No Type _____ # of hours per week _____

Any occupational hazards? Yes No Type _____

Do you practice a particular faith regularly? Yes No Type of Faith _____

What is your marital status? Single and never married Married Widowed Divorced
 Domestic Partner Committed, long-term relationship

Who are the members of your household? _____

Family Medical History

Please list any medical conditions in the family.

Mother _____ Maternal Grandmother _____

Father _____ Maternal Grandfather _____

Daughters _____ Paternal Grandmother _____

Sons _____ Paternal Grandfather _____

Sisters _____ Maternal Aunts/Uncles _____

Brothers _____ Paternal Aunts/Uncles _____

Cousins _____

Review of Symptoms

Circle symptoms for today's visit only

Breast

Breast lump
Breast pain

Cardiac/Vascular

Chest pain
Heart palpitations
Swelling of legs
Varicose veins

Ear, Nose, Throat, Mouth

Head cold
Sinusitis
Sore throat

Endocrine

Thyroid problems

Gastrointestinal

Blood in stool
Constipation
Diarrhea
Heartburn
Hemorrhoids
Nausea/Vomiting

General

Eye problems
Fevers/aching

Sudden weight loss/
gain

Genitourinary

Pain with urination
Problem leaking urine
Urine frequency

Gynecology

Hot flashes
Irregular periods/no
periods
Night sweats
Painful periods

Pelvic pain

STD exposure
Vaginal discharge

Hematologic

Bruising
Swollen glands

Mental Health

Anxiety
Depression
Mood swings

Musculoskeletal

Back pain/strain
Leg/hip pain
Muscle aches

Respiratory

Cough
Shortness of breath

Skin

Abnormal mole
Rashes/lesion