Brandon Gynecology
ASSOCIATES, PA

Compassionate Care for Women

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

continued

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Medical History Form

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

- ◯ Chlamydia _____
- ◯ Genital Herpes _____
- ◯ Genital Warts _____
- ◯ Gonorrhea _____
- ◯ HIV/AIDS _____
- ◯ Hepatitis _____
- ◯ Human Papillomavirus (HPV) _____
- ◯ Pelvic Inflammatory Disease (PID) _____
- ◯ Syphilis _____
- ◯ Trichomoniasis _____

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

- ◯ Abnormal Pap Smears _____
- ◯ Breast Cancer _____
- ◯ Cervical Cancer _____
- ◯ Chronic Pelvic Pain _____
- ◯ Endometrial Polyps _____
- ◯ Endometriosis _____
- ◯ Fibroids _____
- ◯ Fibrocystic Breast Disease _____
- ◯ Infertility _____
- ◯ Ovarian Cancer _____
- ◯ Ovarian Cysts or Tumors _____
- ◯ Painful Sex _____
- ◯ Uterine Cancer/Endometrial Cancer _____
- ◯ 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.

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

continued

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Medical History Form

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 Sclerosis/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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Medical History Form

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.

_____

_____

_____

continued

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Medical History Form

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 ____

Father ____

Daughters ____

Sons ____

Sisters ____

Brothers ____

Maternal Grandmother ____

Maternal Grandfather ____

Paternal Grandmother ____

Paternal Grandfather ____

Maternal Aunts/Uncles ____

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