Brandon Gynecology
ASSOCIATES, PA
Compassionate Care for Women

Medical History Form

Date ______ Date of Birth ______

First Name ______ Maiden/Middle Name ______ Last Name ______

What are your preferred pronouns? ◯ she/her/hers ◯ he/him/his ◯ they/them/theirs ◯ other ______

Who is your primary care physician? ______

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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ASSOCIATES, PA

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 ___ Skyla ___ Paraguard ___ Kyleena
- ◯ 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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ASSOCIATES, PA

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 ______
  - Dates if IV Iron 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 ______
- ◯ Fibromyalgia

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) ______
- ◯ Bariactric Surgery ______
- ◯ Hernia Repair ______
- ◯ LASIK Eye Surgery ______
- ◯ Plastic/Cosmetic Surgery ______
- ◯ Tonsillectomy ______

List any other surgeries with dates and complications.

______

______

______

continued

Brandon Gynecology ASSOCIATES, PA

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 ____

Level of Education ________ 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
Sudden weight loss/gain

Gastrointestinal
Blood in stool
Constipation
Diarrhea
Heartburn
Hemorrhoids
Nausea/Vomiting

General
Eye problems
Fevers/aching

Genitourinary
Pain with urination
Problem leaking urine
Urine frequency
Pelvic pain
STD exposure
Vaginal discharge

Gynecology
Hot flashes
Irregular periods/no periods
Night sweats
Painful periods

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