ADVANCED UROGYNECOLOGY

Female Incontinence • Gynecology • Wellness

MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ D.O.B.: _____

Please share with us the reason for your visit: _____

_____

Which doctor referred you? _____

PAST MEDICAL HISTORY	NO	YES	If yes, please explain		NO	YES	If yes, please explain
Cancer-BRCA tested				Hematology-Other			
Cancer- Breast				ID- Chicken Pox			
Cancer- Cervical				ID- HIV			
Cancer- Colon				ID- MRSA			
Cancer- Endometrial				ID- Other			
Cancer- Lung				ID- Rheumatic Fever			
Cancer- Other				ID- Tuberculosis / Positive PPD			
Cancer- Ovary				ID- Unusual Childhood Disease			
Cancer- Skin				Neurology- Headaches / Migraines			
Cancer- Vaginal				Neurology- Memory Loss / Dementia			
Cancer- Vulvar				Neurology- Neuropathy			
Cardiac- Heart Arrhythmia				Neurology- Other			
Cardiac- Hear Disease				Neurology- Seizures / Epilepsy			
Cardiac- High Blood Pressure				Neurology- Stroke / TIA			
Cardiac- High Cholesterol				Ortho- Chronic Back Pain			
Cardiac- Other				Ortho- Degenerative Joint Disease			
Dermatology- Acne				Ortho- Fractures			
Dermatology- Eczema / Psoriasis				Ortho- Other			
Dermatology- Other				Psych- ADD			
ENT- Hearing Loss				Psych- Anxiety Disorder			
ENT- Other				Psych- Bipolar Disease			
Endocrinology- Diabetes				Psych- Depression			
Endocrinology- Elevated Prolactin				Psych- Eating Disorder			
Endocrinology- Osteopenia				Psych- Other			
Endocrinology- Osteoporosis				Psych- PMS / PMDD			
Endocrinology- Other				Pulmonary- Asthma			
Endocrinology- Thyroid Problems				Pulmonary- COPD / Emphysema			
Eyes- Cataracts				Pulmonary- Other			
Eyes- Glaucoma				Pulmonary- Seasonal Allergies/Allergic			
Eyes- Other				Pulmonary- Sleep Apnea			
Eyes- Vision Loss				Rheumatology- Arthritis			
GI- Colon Polyps				Rheumatology- Autoimmune Disease			
GI- Crohn's / Ulcerative Colitis				Rheumatology- Fibromyalgia			
GI- Gallbladder Disease				Rheumatology- Other			
GI- Hemorrhoids				Rheumatology-Restless Leg Syndrome			
GI- Irritable Bowel Syndrome				Urology- Frequent Urinary Tract Infec			
GI- Liver Disease / Hepatitis				Urology- Hematuria (Blood in Urine)			
GI- Other				Urology- Interstitial Cystitis			
GI- Reflux / Stomach Ulcers				Urology- Kidney Disease			
GI- Vitamin Deficieny				Urology- Kidney Infec			
Hematology- Anemia				Urology- Kidney Stones			
Hematology- Bleeding Disorder				Urology- Other			
Hematology- Blood Clotting Disorder				Urology- Urinary Incontinence			
Hematology- Blood Transfusion				Wt Management- Obesity			
Hematology-DVT/Pulmonary Embolism				Wt Management- Other			

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SURGICAL HISTORY *(Please list all procedures, not just OB-GYN)*

Date	Type of Surgery	Reason for Surgery

MEDICATIONS

Medication Name	Dose	Frequency

ALLERGIES / ADVERSE REACTIONS

Drug	What is your reaction?

GYN HISTORY *(please circle)*

Frequency of Cycle:	Monthly	< 21 days	>35 days	very irreg.
Duration of flow in days:				
Amount of flow:	light	moderate	heavy	
Cramps:	no	yes		
Current birth control:	abstinence	condom	depo	essure
	IUD	nexplanon	patch	pills
	Ring	rhythm	tubal ligation	vasectomy
	none			
If applicable: Age at Menopause				
Sexual Orientation:	Heterosexual	Homosexual	Bisexual	
Sexually active:	yes	no		

OB-GYN HISTORY *(please check)*

					If yes, please explain:
History of STD- PID		Yes		No	
History of abnormal PAP		Yes		No	
Date of last PAP					
HPV test		Yes		No	
HPV vaccination		Yes		No	
History of breast problems		Yes		No	
History of abnormal Mammogram		Yes		No	
Date of Last Mammogram					
History of Cervical Dysplasia		Yes		No	
History of Endometriosis		Yes		No	
History of Fibroids		Yes		No	
History of Infertility		Yes		No	
History of Ovarian problems		Yes		No	
History of PCOS		Yes		No	
Date of last Colonoscopy					
Date of last DEXA					

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FAMILY HISTORY

Family Member	Medical Condition	Age at Diagnosis

SOCIAL HISTORY *(please circle)*

Smoking status:	never	former	daily	sometimes		
Smoking, how much?						
Alcohol intake:	none	occasional	moderate	heavy		
Illicit drugs?	none	yes				
Caffeine intake	none	occasional	moderate	heavy		
Exercise level:	none	occasional	moderate	heavy		
Diet:	regular/vegetarian	vegan	no gluten	cardiac	diabetic	
Marital status:	married	single	divorced	separated	widow	domestic partner
Hx of domestic violence:	yes	no				
Education:	<8th gr	8-12th	2 yr college	4 yr college	postgraduate	
Occupation:						
Religion:						
Seat belts used routinely?	yes	no				
Is a blood transfusion acceptable in an emergency?	yes	no				

OBSTETRIC HISTORY

Date	**Outcome** *(specify Vaginal, C-section, Miscarrage or Abortion)*	**Full Term**	**M / F**	**Birth Weight:**
		No / Yes		
Date	**Outcome** *(specify Vaginal, C-section, Miscarrage or Abortion)*	**Full Term**	**M / F**	**Birth Weight:**
		No / Yes		

PATIENT'S PHARMACY

Name	Address	Phone

PATIENT'S PROVIDERS *(Please list your primary doctor and any other doctors you see)*

Name	Specialty	Address & Phone Information

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BLADDER AND BOWEL SURVEY

Do you rush to empty your bladder? _____
How frequently? _____

Do you leak urine on the way to the bathroom? _____
How many times per day? _____

Do you suddenly have the urge to urinate? _____
How many times per day? _____

Do you get up at night to urinate? _____
How many times per night? _____

Do you have any bladder accidents at night? _____
How many times per night? _____

Do you see blood in the urine? _____

Do you have kidney stones? _____

Do you leak urine with cough, laugh, sneeze? _____

Do you have frequent urine infections? _____
How frequently? _____

Do you wear a pad because of urine loss? _____

Do you have sudden urge to move your bowels? _____
How frequently? _____

Do you have bowel accidents? _____
How frequently? _____

How often do you move your bowels? _____
Are they runny, soft, or hard? _____

Have you tried:

- ☐ Detrol
- ☐ Oxybutynin
- ☐ Ditropan
- ☐ Enablex
- ☐ Vesicare
- ☐ Sanctura
- ☐ Elavil
- ☐ Flomax
- ☐ Elmiron
- ☐ Pelvic Floor Therapy / Biofeedback
- ☐ Urgent PC
- ☐ Interstim

Are you interested in:

- ☐ Weight loss programs
- ☐ Hormonal therapy
- ☐ Therapy for low libido
- ☐ Natural therapies for menopause/sleep/anxiety