*Auburn Urogynecology and Women's Health*

| Name: | DOB: | Age: |
|---|---|---|
| Referring Doctor: | Weight : | Height: |

**What brings you to the office today?**

**ALLERGIES (list reaction):** ❒ No Known Drug Allergies

Are you allergic to: ❒ Latex ❒ Iodine

**List your prescribed medications and over the counter medications, herbs, and supplements:**

| Drug Name | Dose | Frequency | Drug Name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PAST MEDICAL HISTORY**

| Have you ever had… | Yes | No | Please Explain |
|---|---|---|---|
| Anemia or blood disorder | | | |
| Asthma | | | |
| Birth defects or inherited diseases | | | |
| Breast problems | | | |
| Cancer of the breast | | | |
| Cancer of the ovary or female organs | | | |
| Cancer-other | | | |
| Convulsions/seizures/epilepsy | | | |
| Depression | | | |
| Diabetes | | | |
| Ear problems | | | |
| Eye problems/glaucoma | | | |
| Gastro-intestinal problems | | | |
| Heart problems | | | |
| Hepatitis | | | |
| High blood pressure | | | |
| HIV | | | |
| Kidney or bladder problems | | | |

| | | | |
|---|---|---|---|
| Lung disorders | | | |
| Nose or throat problems | | | |
| Sleep apnea | | | |
| Thyroid problems | | | |
| Varicosities | | | |
| Other: | | | |

**Surgical History**

| **Have you had……** | **Yes** | **Year** | |
|---|---|---|---|
| Hysterectomy | | | If yes, do you still have your ovaries? |
| LEEP/Conization of Cervix | | | |
| Sterilization | | | If yes, what method? |
| Pelvic Surgery | | | |
| Bladder Surgery | | | |
| Insertion of Medical Devices (pacemaker,etc) | | | If yes, please list: |
| C-Section: | | | |
| Other: | | | |

**FAMILY HEALTH HISTORY**

| **Illness** | **Yes** | **Which Relative(S)** | **Illness** | **Yes** | **Which Relative(s)** |
|---|---|---|---|---|---|
| Breast cancer | | | Kidney disease | | |
| Cervical cancer | | | Neurological disease | | |
| Endometrial cancer | | | Other: | | |
| Ovarian cancer | | | Hereditary diseases | | |
| Other cancer: | | | Psychiatric disease | | |
| Diabetes | | | Stroke | | |
| Heart disease | | | Thyroid problems | | |
| High blood pressure | | | | | |

**SOCIAL HISTORY**

**Occupation:** **Highest education level completed:**

**Exercise:** ❒ None ❒ Occasional ❒ Moderate ❒Heavy

**Marital Status:** ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed ❒ Domestic Partner

**Tobacco use:** ❒ Never ❒ Former ❒ Current: Pks/day_____ # of years_____ or Year quit _____

**Alcohol intake:** ❒ None ❒ Occasional ❒ Moderate ❒ Heavy

**Caffeine intake:** ❒ None ❒ Occasional ❒ Moderate ❒ Heavy

**Illicit drug use:** ❒ No ❒ Yes : Please list:

**Are you sexually active:** ❒ Yes ❒ No

**Safety:** Have you been sexually abused, threatened, or hurt by anyone?

**OBSTETRIC HISTORY**

Number of times pregnant:_____ Miscarriages:_____ Abortions:_____ Living Children:_____
Number of vaginal births:_____ C-sections:_____
Pregnancy complications:

| GYN HISTORY | | | |
|---|---|---|---|
| First day of LMP? | | | |
| Menstrual flow | ❒ Light ❒ Moderate ❒ Heavy | Age period started : | |
| Are you menopausal | ❒ No ❒ Yes If yes, at what age: | | |
| Birth control method? | | | |
| Date of last pap smear: | Any abnormal? | If yes, when? | |
| Date of last mammogram: | Any abnormal? | If yes, when? | |
| Date of last colonscopy: | Any abnormal? | If yes, when? | |
| Date of last Dexascan: | | | |

**Check all that apply**:  heavy bleeding  irregular bleeding  severe menstrual cramping
 pain with intercourse  any other pelvic pain  PMS  hot flashes  vaginal dryness
 night sweats  loss of libido  urinary problems  leaking of urine  bulging feeling in vagina
 herpes  genital warts  any other sexually transmitted disease:_____

**URINARY WELLNESS**

| Do you…. | Yes | No | Do you… | Yes | No |
|---|---|---|---|---|---|
| leak urine against your will? | | | have a strong sense of urgency to void just prior to you leaking urine? | | |
| leak urine while coughing, exercising, sneezing, lifting? | | | wear a pad to protect yourself against urine loss? | | |

| Review of Systems | Check all that apply |
|---|---|
| Constitutional | ❑ fatigue ❑ fever ❑ weight gain ❑ weight gain |
| Skin | ❑ moles ❑ rashes ❑ other: |
| Eyes | ❑ vision changes ❑ irritation |
| Ears/nose/throat/mouth | ❑ hearing loss ❑ ear pain ❑ sinus problems ❑ sore throat ❑ snoring ❑ dry mouth ❑ mouth ulcers |
| Respiratory | ❑ shortness of breath ❑ cough ❑ wheezing ❑ coughing blood |
| Cardiovascular | ❑ chest pain ❑ palpitations ❑ exercise intolerance |
| Gastrointestinal | ❑ heartburn ❑ difficulty swallowing ❑ nausea ❑ vomiting ❑ abdominal pain ❑ diarrhea ❑ constipation ❑ changes in bowel movements |
| Genito-urinary | ❑ blood in urine ❑ abnormal bleeding ❑pain ❑ trouble urinating ❑ urgency ❑ painful urination ❑ urinary frequency ❑ rash ❑ lesion ❑ discharge ❑ odor |
| Endocrine | ❑ menstrual problems ❑menopausal symptoms ❑ sexual problems |
| Musculoskeletal | ❑ muscle aches ❑weakness ❑ arthritis ❑ back pain |
| Neurological | ❑ headaches ❑ dizziness ❑ weakness ❑ numbness ❑seizures |
| Psychiatric | ❑ depression ❑ anxiety ❑ alcoholism ❑ sleep problems |

**Please add any other information you would like your healthcare provider to know:**

**Signature:** **Date:**