MEDICAL INFORMATION

NAME: ____ **Date of birth:** ____/____/______**Today's date:** __________

Reason for today's visit: ❒Annual check up ❒Irregular periods ❒Vaginal discharge ❒Others______________________

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Please list all medications / dosages you are currently taking, including vitamins, herbs and over-the-counter medications.

1.____ 6.____
2.____ 7.____
3.____ 8.____
4.____ 9.____
5.____ 10.____

Please list all medication allergies, type of reactions and other non-medication allergies:

1.____ 4.____
2.____ 5.____
3.____ 6.____

Please list all previous and current medical illnesses:

❒Asthma ❒High blood pressure ❒High cholesterol ❒Thyroid disease ❒Mitral valve prolapse ❒Stroke
❒Heart disease ❒Sugar diabetes ❒Hepatitis ❒Epilepsy ❒Blood clots in legs or lung ❒Psychiatric problem
❒Others ____

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❒Cancer - Type ____

Gynecologic history

❒Abnormal pap smear Grade ___________ Type of treatment ________________________________ Year _______
❒Breast mass or biopsy ❒Endometriosis ❒ Uterine fibroids ❒PCOS
❒Herpes infection ❒Genital warts ❒HPV ❒Chlamydia ❒Gonorrhea ❒Syphilis
❒Loose urine on coughing or sneezing ❒Have sensation that organs are falling out of the vagina
❒Pain with intercourse ❒Low sex drive ❒Unable to achieve orgasm ❒Bleeding after intercourse
Others female problems: ____
Are you involved in a same sex relationship? ❒N ❒Y – Please advise me personally if you do not feel comfortable answering this question
Other female related problems ____
When was your last pap smear? _________________________ When was your last colonoscopy? __________________
When was your last mammogram? ______________________ When was your last bone density test? ______________

Menstrual history:

When was your last normal period?____________________ Age of your first menstrual period ____________________
What is the number of days between periods (Period interval) __________ How long does your period last?_______days
Do you have vaginal bleeding between periods? ❒No ❒Yes If yes, is it ❒Light ❒Heavy?
Do you have cramps with your periods? ❒No ❒Yes. Please rate severity of your cramps from **1**(Mild)/**10** (Severe) _____
Is your menstrual flow? ❒Normal ❒Moderate ❒Heavy. How many pads/tampons do you change on a heavy day? _____

Do you pass blood clots during cycles? ❒No ❒Yes / If yes, ❒Small clot (Grape size or smaller) ❒Large (Lemon size)

Do you have accidents such as blood soaking through your clothes during periods ❒No ❒Yes

Are you menopausal? ❒No ❒Yes If yes, what year? _____________

Do you have any menopausal symptoms? ❒Hot flashes ❒Night sweat ❒Vaginal dryness ❒Decreased libido

❒Painful sexual intercourse ❒Other____

Have you had the following vaccine and what year?

HPV ❒No ❒Yes Year_______ Flu ❒No ❒Yes Year______ Covid ❒No ❒Yes Year________

Tetanus ❒No ❒Yes Year_______ Shingle ❒No ❒Yes Year______

Contraception history

What kind of contraception are you currently using? ❒None ❒Abstinence ❒Condom ❒Withdrawal ❒Rhythm

❒Birth control pills. Name of the pills____

❒Ortho Evra patch ❒Nuvaring ❒Nexplanon ❒Depo-Provera injection

❒IUD / Name of IUD & date of insertion ____

❒Tubal ligation ❒Bilateral salpingectomy (Removal of both tubes) ❒Essure ❒Vasectomy

Pregnancy history:

How many times have you been pregnant? ____________________ Number of living children____________________

Number of miscarriages_________ Number of abortions__________ Number of ectopic (Tubal) pregnancies_________

Previous surgeries (Including C-sections, tubal ligation, tonsillectomy, and plastic / cosmetic surgeries etc…)

1.__________________________________Year_______ 6.__________________________________Year_______

2.__________________________________Year_______ 7.__________________________________Year_______

3.__________________________________Year_______ 8.__________________________________Year_______

4.__________________________________Year_______ 9.__________________________________Year_______

5.__________________________________Year_______ 10._________________________________Year_______

Family history: First degree relative (Father, mother, brother, sister) Second degree (Uncles, aunts, nephews, nieces…)

	Relationship		**Relationship**
❒Diabetes	____________________	❒Breast cancer	____________________
❒Hypertension	____________________	❒Colon cancer	____________________
❒Heart disease	____________________	❒Ovarian cancer	____________________
❒Blood clots	____________________	❒ Stroke	____________________

Others____

Mother ❒Living ❒Deceased / Age and cause of death ______________________________

Father ❒Living ❒Deceased / Age and cause of death ______________________________

Sisters ❒Living ❒Deceased / Age and cause of death ______________________________

Brothers ❒Living ❒Deceased / Age and cause of death ______________________________

Social history:

Do you smoke? ❒No ❒Yes # of cigarettes per day ____________________for__________years

Do you smoke marijuana? ❒No ❒Yes

Do you drink alcohol excessively? ❒No ❒Yes How many drinks per day______________________________

Do you use recreational drugs? ❒No ❒Yes Type: ____

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