

Scott Gynecology & Pelvic Surgery

Legal Name _____ **Date of Birth** _____ **Date** _____
First Middle Initial Last
Phone Number (work) _____ **(home)** _____ **(cell)** _____
E-mail address _____

Fill out this form for your **FIRST** visit to Scott Gynecology & Pelvic Surgery.
 This information is confidential. It will not be shared without you permission.

Family Health History

Has anyone in your family (including grandparents, parents, siblings) ever had the following? Who?

Yes	No		Yes	No		Yes	No	
___	___	Heart disease	___	___	Cancer	___	___	Breast disease
___	___	High blood pressure	___	___	Diabetes	___	___	Birth defects
___	___	Stroke	___	___	Thyroid disease	___	___	Multiple births
___	___	Blood clots in legs/lungs	___	___	Tuberculosis	___	___	Depression/schizophrenia
___	___	High cholesterol	___	___	Osteoporosis	___	___	Drug/alcohol abuse

Medical History: Have you ever had?:

Yes	No		Yes	No		Yes	No	
___	___	Breast cancer	___	___	Thyroid Disease	___	___	Multiple sclerosis
___	___	Cancer (other)	___	___	Hepatitis	___	___	Neurological problems
___	___	High cholesterol	___	___	Lung/tuberculosis	___	___	Head injury
___	___	High blood pressure	___	___	Epilepsy/seizures	___	___	Mental health problems (depression/anxiety)
___	___	Heart disease	___	___	Pelvic/hip injury	___	___	Drug abuse
___	___	Gall bladder disease	___	___	Asthma	___	___	Alcohol abuse
___	___	Bowel disease/problems	___	___	Ulcer	___	___	Migraine Headaches
___	___	Bleeding disorder	___	___	Hearing Problems	___	___	Chickenpox
___	___	Osteoporosis/Osteopenia	___	___	Stroke	___	___	Headaches
___	___	Diabetes	___	___	Kidney disease	___	___	Glaucoma
___	___	Mitral valve prolapse or heart problems requiring antibiotics for dental work	___	___		___	___	
___	___	Other _____						

Medication & Allergy History: Are you allergic to?:

Yes	No		Yes	No		Yes	No	
___	___	Penicillin	___	___	Sulfa	___	___	Other antibiotics/medication
___	___	Latex	___	___	Iodine	___	___	Other _____

Describe your reaction(s) _____

List all **prescribed medicines** you now take _____

List all **vitamins** and **herbs** you take _____

Do you take calcium supplements? ___ yes ___ no

Surgery and Hospitalizations: Give year or your age when done.

D and C _____	Cesarean section _____
Appendectomy _____	Tubal ligation _____
Gall bladder _____	Laparoscopy _____
Breast surgery (any type) _____	Hysterectomy _____ Ovaries removed? ___ yes ___ no
Other gyn surgery _____	Tonsillectomy _____
Have you ever had a blood transfusion? yes ___ no ___	Other hospitalizations _____
When _____	

Gynecologic History/Immunization History:

Date of last pelvic exam _____	Date of last Pap smear _____	Your weight: _____
Any abnormal pap smears ___ yes ___ no	Type of treatment _____	Your height: _____
Date and place of last mammogram _____		
Have you had screen for colon cancer (50 years or older) stool blood test, sigmoidoscopy, or colonoscopy? ___ yes ___ no		
Have you had genital herpes, chlamydia, gonorrhea or pelvic inflammatory disease? ___ yes ___ no		
Do you currently have vaginal itching or odor? ___ yes ___ no		
Have you had your cholesterol checked in the past 3 years? ___ yes ___ no		
Have you had a Tetanus shot within the last 10 years? ___ yes ___ no		
Have you had a Hepatitis B Vaccine (health care worker or under age 15)? ___ yes ___ no		
Have you had the HPV vaccine series? (age 9-26) ___ yes ___ no		
Have you had a measles, mumps, rubella vaccine? ___ yes ___ no		
Have you completed a Health Care Proxy? ___ yes ___ no		

Menstrual History: (if menstruating)

Date of last period? _____
 How old were you with your first period? _____
 Do you have bad cramps? (Rate 1-10) ___ yes ___ no ___ rate
 Is heavy flow a problem? ___ yes ___ no
 Do you have PMS? ___ yes ___ no
 Was the last period normal for you? ___ yes ___ no

Are your periods regular? ___ yes ___ no
 Do you bleed between periods? ___ yes ___ no
 Are your periods prolonged more than nine days? ___ yes ___ no
 Do you take medicine for cramps? ___ yes ___ no
 Do periods/PMS keep you home? ___ yes ___ no

Menopause History: (if menopausal)

Do you have hot flashes? ___ yes ___ no
 Do you have vaginal dryness? ___ yes ___ no
 Do you have urinary frequency? ___ yes ___ no

Have you had a bone density test? ___ yes ___ no
 Have you ever used hormone replacement? ___ yes ___ no
 Do you have problems with low sex drive? ___ yes ___ no
 Do you have loss of urine (incontinence)? ___ yes ___ no
 Do you have overactive bladder? ___ yes ___ no

Pregnancy History: (list sex, year of birth, weight and type of delivery)

Living children _____ Stillbirths _____ Miscarriages _____ Abortions _____ Ectopic pregnancy _____
 Did your mother take DES when pregnant with you? ___ yes ___ no
 Have you had any complications with pregnancies or abortions? ___ yes ___ no
 Have you had problems becoming pregnant? ___ yes ___ no

Sexual History: (Complete any that apply to you)

Age you started having intercourse _____
 Do you have a male partner? ___ yes ___ no
 Do you have a female partner? ___ yes ___ no
 Is your sexual activity satisfactory? ___ yes ___ no
 Any pain with intercourse? ___ yes ___ no
 Is your relationship mutually monogamous? ___ yes ___ no
 Do you have other sexual partners? ___ yes ___ no
 Does your partner have other partners? ___ yes ___ no
 How many partners have you had? _____
 Do you engage in oral sex? ___ yes ___ no
 Do you engage in anal intercourse? ___ yes ___ no

Have you encountered verbal, physical or sexual abuse? ___ yes ___ no
 Are you or your partner using birth control? ___ yes ___ no
 What type? _____
 Are you satisfied with your birth control method? ___ yes ___ no
 Has your partner had a vasectomy? ___ yes ___ no
 Does your partner use a condom? ___ yes ___ no
 Do you need information of safe sex practices? ___ yes ___ no
 Have any of your partners been at risk for AIDS (heterosexual with multiple partners, bisexual and history of IV drug abuse)? ___ yes ___ no
 Do you wish to have HIV testing? ___ yes ___ no

Health Habits:

Do you smoke? ___ yes ___ no
 How many packs a day? _____
 Have you smoked in the past? ___ yes ___ no
 Quit date: _____
 Do you use street drugs? ___ yes ___ no
 Have you in the past? ___ yes ___ no
 What kind(s) _____
 IV Drug use? ___ yes ___ no
 How much alcohol do you drink? _____
 Do you think you have a problem with alcohol? ___ yes ___ no
 Do you have any aesthetic concerns (i.e. hair, skin)? ___ yes ___ no
 If so, what are they? _____

Do you have body piercing? ___ yes ___ no
 Do you have tattoos? ___ yes ___ no
 Do you exercise regularly? ___ yes ___ no
 Do you follow a special diet? ___ yes ___ no
 Do you eat a balanced diet? ___ yes ___ no
 Do you have trouble controlling what you eat? ___ yes ___ no
 How do you feel about your current weight? _____
 Do you make yourself vomit? ___ yes ___ no
 Do you have a problem with anorexia? ___ yes ___ no
 Do you wear seat belts when driving? ___ yes ___ no
 Do you see a dentist regularly? ___ yes ___ no
 What are you using for sun protection? _____

Social History:

Education: ___ high school ___ college ___ post graduate
 Marital Status: M / D / W / SEP / Living with
 Race _____ Jehovah's Witness? _____
 Who referred you to our office? _____
 Who is your primary care physician? _____
 Other doctors you see? (general and specialists) _____
 What brings you to our office today? _____
 Is there anything you would like to discuss? _____