

Patient Medical History - Urogynecology

Today's Date: _____ Appt. Date _____ Provider you are seeing _____

First Name _____ MI _____ Last Name _____

Date of Birth _____/_____/_____ Name of Primary Care Physician: _____

Medications

Please list all medication or treatments you are currently taking. Include over-the-counter or herbal drugs.

Medications	Dosage	Frequency	Reason
1			
2			
3			
4			
5			
6			
7			

Allergies

Iodine or seafood Yes _____ No _____

Latex Yes _____ No _____

Peanuts Yes _____ No _____

Medications Yes _____ No _____

Specify Medications _____

Social History

Alcohol Never _____ Yes _____

what, when, and how much _____

Tobacco Never _____ Yes _____

what, when, and how much _____

Drug Use Never _____ Yes _____

what, when, and how much _____

Exercise Never _____ Yes _____

what, when, and how much _____

Past Medical History

Please answer yes/no to the following questions. Specify any yes answers in further detail below.

Condition	Yes	No	Condition	Yes	No
Thyroid Disease			Kidney/Bladder Disease		
Heart Disease			Diabetes		
Hypertension			Gallbladder Disease		
Lung Disease			Cancer		
Anemia			Psychological		
Blood Transfusions			Liver Disease		
Blood clots, phlebitis			Gastrointestinal		
Migraine Headaches			Rectal		
Urinary Tract Infection			Neurological		
Urinary Incontinence			Autoimmune		
Pelvis Organs Falling			Musculoskeletal		

Past surgical History

Please list all major surgeries or hospitalization in the table.

Mo/Year	Procedure	Reason

Please be aware that it is the policy of Northwest OB-Gyn Physicians to not withhold blood products if it may be required to save the life of the patient.

Family Medical History

Medical Problems	Mom	Dad	Sibling	Maternal Grandpa	Maternal Grandma	Paternal Grandpa	Paternal Grandma	Mat Aunt	Mat Uncle	Pat Aunt	Pat Uncle	Child
Heart Disease												
Diabetes												
Hypertension												
High Cholesterol												
Stroke												
Neurologic Disorder												
Bleeding / Clotting Disorders												
Cancer												
- Breast												
- Uterine												
- Ovarian												
- Cervical												
- Colon												
Thyroid Disease												
Kidney Disease												
Liver Disease												
Endocrine												
Psychologic Disorder												
Autoimmune/ Rheumatologic Disorders												
Other Genetic Disorders												
Birth Defect												
Pelvic relaxation/prolapse												

What ethnicity do you consider yourself to be? please check one White Black/African American Hispanic
 Asian/Pacific Islander Native American/Alaskan Native Other

Obstetrical History

How many pregnancies have you had? _____ Please list them all and the outcome of each below.

	Date	Gestational weeks	Length of labor	Type of delivery	Sex M/F	Birth weight	Place of Birth	Preterm Y/N	Complication
1.									
2.									
3.									
4.									
5.									

Gynecologic History

At what age did you start having Periods? _____ What is your Period Duration _____
 Date of Last Menstrual Period _____ Date of last Pap _____
 Date of Prior Menstrual Period _____ Date of last Mammogram _____
 Do you have Regular Periods? How often? _____ Date of last Bone Scan _____

Condition	Yes	No	Condition	Yes	No
Painful Periods			Problem with intercourse		
Other Symptoms during a period			Breast discharge/ tenderness/ lumps		
Heavy Bleeding			Infertility		
Bleeding between cycles			Birth Control		
Abnormal Vaginal Discharge/Itch			Permanent Sterilization		
History of STD's			Hormone Therapy		
History of abnormal Pap Smears			Pelvic relaxation/prolapse		
Sexually active			Other gynecologic issues		

This form completed by me the patient and is accurate to the best of my knowledge _____
Patient Signature Date