UROLOGY ASSOCIATES OF SAN LUIS OBISPO *A Medical Group, Inc.*

GYNECOLOGY DIVISION

NAME: _____ DOB:_____ TODAY'S DATE: _____

MEDICAL HISTORY (PLEASE CIRCLE FOR ALL MEDICAL ILLNESSES YOU HAVE HAD)

ALCOHOL ABUSE	***DIVERTICULITIS***	***INFERTILITY***
ALLERGIES	***DIVERTICULOSIS***	***IRRITABLE BOWEL SYNDROME***
ANEMIA	***DRUG ABUSE***	***KIDNEY DISEASE***
ANOREXIA	***EMPHYSEMA***	***KIDNEY INFECTION***
ANXIETY	***FIBROMYALGIA***	***LOW THYROID***
AUTOIMMUNE DISORDER	***GALLSTONES***	***MACULAR DEGENERATION***
BIPOLAR	***GASTRITIS***	***MENTAL RETARDATION***
BLADDER INFECTION, CHRONIC	***GLAUCOMA***	***MIGRAINE HEADACHE***
BLEEDING DISORDER	***HEADACHE***	***OBESITY***
BRONCHITIS	***HEART ATTACK***	***OSTEOARTHRITIS***
BULIMIA	***HEART DISEASE***	***OSTEOPENIA***
CANCER, BREAST	***HEART FAILURE***	***OSTEOPOROSIS***
CANCER, CERVICAL	***HEMORRHOIDS***	***PANCREATITIS***
CANCER, COLON	***HEPATITIS A***	***PULMONARY EMBOLISM***
CANCER, OVARIAN	***HEPATITIS B***	***REFLUX DISEASE***
CANCER, UTERUS	***HEPATITIS C***	***SCHIZOPHRENIA***
CIRRHOSIS	***HERNIA***	***SEIZURES***
DEEP VEIN THROMBOSIS	***HIGH BLOOD PRESSURE***	***SEXUALLY TRANSMITTED DISEASE***
DEMENTIA	***HIGH CHOLESTEROL***	***STROKE***
DEPRESSION	***HIGH THYROID***	***TUBERCULOSIS***
DIABETES	***INCONTINENCE***	***ULCERS***

PAST EXAMINATIONS (PLASE INDICATE THE EXAMINATIONS YOU HAVE HAD AND THE APPROX TIME FRAME BY CIRCLING THE APPROPRIATE ANSWER)

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR: *YES* *NO*

*IF YES, WHAT YEAR DID YOU HAVE AN ABNORMAL PAP SMEAR? _____

INDICATE YOUR CHOLESTEROL LEVEL IF KNOWN: *LOW* *HIGH* *NORMAL*

IF YOU HAVE HAD A COLONOSCOPY, WHAT YEAR?_____

IF YOU HAVE HAD A BONE DENSITY, WHAT YEAR?_____

INDICATE THE BONE DENSITY RESULTS IF KNOWN: NORMAL LOW BONE MASS OSTEOPENIA OSTEOPOROSIS

SOCIAL HISTORY (PLEASE CIRCLE THE APPROPRIATE ANSWER)

ARE YOU: SINGLE MARRIED DIVORCED WIDOWED SEPARATED PARTNERED

UP TO WHAT YEAR OF SCHOOLING OR DEGREE HAVE YOU COMPLETED? ELEMENTARY HIGH SCHOOL 2YR COLLEGE 4YR COLLEGE MASTERS DOCTORATE

OCCUPATION:_____

WHAT LANGUAGE DO YOU SPEAK? ENGLISH SPANISH OTHER _____

WHAT LANGUAGE DO YOU READ? ENGLISH SPANISH OTHER _____

WHAT KIND OF DIET DO YOU FOLLOW? LOWFAT LOWCARB HIGH PROTEIN VEGETARIAN OTHER_____

SOCIAL HISTORY (CONTINUED)

HOW OFTEN DO YOU EXERCISE? NONE 1-2 DAYS/WK 3-4 DAYS/WK 4-5 DAYS/WK 5-7 DAYS/WK
WHAT DO YOU DO FOR EXERCISE? _____

ARE YOU SEXUALLY ACTIVE WITH ANYONE? _____ PARTNER(S) SEX: M F BOTH
HOW MANY PARTNERS HAVE YOU HAD? _____

WHAT BIRTH CONTROL METHOD ARE YOU USING NOW? _____

DO YOU DOUCHE? YES NO

HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE? YES NO
IF YES PLEASE INDICATE THE TYPE OF STD YOU HAVE HAD: _____

HAVE YOU EVER BEEN IN AN ABUSIVE RELATIONSHIP? YES NO
ARE YOU CURRENTLY IN AN ABUSIVE RELATIONSHIP? YES NO

DO YOU SMOKE? YES NO IF YES, HOW MANY PACKS PER DAY? _____
ARE YOU READY TO QUIT? YES NO

HAVE YOU SMOKED IN THE PAST? YES NO IF YES, HOW MUCH, HOW LONG, AND YEAR YOU QUIT?
_____

DO YOU DRINK ALCOHOL NOW OR HAVE YOU IN THE PAST? YES NO
IF YES, HOW MANY ALCOHOLIC DRINKS DO YOU HAVE? _____
DO YOU THINK YOU HAVE AN ALCOHOL PROBLEM? YES NO
DO YOU DRINK CAFFEINE PRODUCTS? YES NO IF YES, HOW MANY CAFFEINE DRINKS DO YOU HAVE PER DAY?
_____

DO YOU USE ANY STREET DRUGS NOW OR HAVE IN THE PAST? YES NO
WHICH STREET DRUGS HAVE YOU USED? _____
IF YOU HAVE QUIT, WHEN DID YOU QUIT? _____

DO YOU THINK YOU HAVE A DRUG PROBLEM? YES NO

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF MEDICALLY NECESSARY? YES NO
ARE YOU JEHOVAHS WITNESS? YES NO

DO YOU HAVE A LIVING WILL, DIRECTIVE, OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE? YES NO
IF NO, I RECOMMEND THAT YOU COMPLETE ONE.

WHEN YOU RIDE IN A CAR DO YOU WEAR SAFETY BELTS? YES NO
DO YOU DO BREAST SELF-EXAMS ON A REGULAR BASIS? YES NO
DO YOU TAKE CALCIUM AND OR VITAMIN D REGULARLY? YES NO

FAMILY HISTORY (PLEASE WRITE IN THE FAMILY MEMBER (BLOOD REALATED ONLY WHO HAS HAD THE LISTED ILLNESS)

ALCOHOL ABUSE _____
ANOREXIA _____
ANXIETY _____
AUTOIMMUNE DISORDER PLEASE INDICATE WHAT TYPE. _____
BIPOLAR _____
BLEEDING DISORDER _____

FAMILY HISTORY (PLEASE WRITE IN THE BLOOD RELATIVE WHO HAS HAD THE LISTED ILLNESS)

BULIMIA _____
CANCER, BREAST _____
CANCER, CERVICAL _____
CANCER, COLON _____
CANCER, OVARIAN _____
CANCER, UTERUS _____
DEEP VEIN THROMBOSIS _____
DEMENTIA _____
DEPRESSION _____
DIABETES _____
DRUG ABUSE _____
HEART ATTACK _____
HEART DISEASE _____
HEART FAILURE _____
HIGH BLOOD PRESSURE _____
HIGH CHOLESTEROL _____
HIGH THYROID _____
KIDNEY DISEASE _____
LOW THYROID _____
MENTAL RETARDATION _____
OBESITY _____
OSTEOARTHRITIS _____
OSTEOPENIA _____
OSTEOPOROSIS _____
PULMONARY EMBOLISM _____
SCHIZOPHRENIA _____
SEIZURES _____
STROKE _____
ANY OTHER _____

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL PROBLEMS YOU ARE EXPERIENCING CURRENTLY)

ANXIETY
DEPRESSION
FATIGUE
HEADACHE
FEVER
NIGHT SWEATS
WEIGHT GAIN
WEIGHT LOSS
RASH
COUGH, CHRONIC
SHORTNESS OF BREATH
BLOOD IN URINE
BURNING WITH URINATION
FREQUENT URINATION
INCONTINENCE
NIGHT TIME URINATION
BREAST LUMP
BREAST PAIN
GENITAL SORES
PAINFUL INTERCOURSE
PELVIC PAIN
VAGINAL DISCHARGE
BLOOD IN STOOL
CONSTIPATION
HEARTBURN
NAUSEA
VOMITING
BLACK STOOL
ABDOMINAL PAIN
CHEST PAIN
PALPITATIONS

MEDICATIONS (PLEASE FILL OUT AS COMPETELY AS POSSIBLE. INCLUDE PRESCRIPTIONS, OVER THE COUNTER, & VITAMINS/HERBS)

MEDICATION	DOSAGE	FREQUENCY	REASON

_____

_____

ALLERGIES OR ADVERSE REACTIONS TO MEDICATION

MEDICATION REACTION

_____

_____

_____

_____

_____

GYN HISTORY

HOW OLD WERE YOU WHEN YOUR PERIOD STARTED?_____

HOW OFTEN ARE YOUR PERIODS?_____

HOW LONG DO YOUR PERIODS LAST? _____

WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD? _____

DO YOU HAVE BLEEDING OR SPOTTING BETWEEN PERIODS? _____

Do you have any bleeding or spotting after intercourse? _____

Do your have problems with your period? _____

Do you have any significant pain with your periods? _____

Do you use any medications to relieve the pain? _____

Do you have other pelvic or abdominal pain any other times? _____

IF YOU HAVE GONE THROUGH MENOPAUSE, HOW OLD WERE YOU?_____

OBSTETRICAL HISTORY (HOW MANY CHILDREN HAVE YOU DELIVERED? _____)

YEAR	WEEKS GESTATION	SEX	BIRTHWEIGHT	TYPE OF DELIVERY	COMPLICATIONS

DO YOU HAVE ANY FOSTER, ADOPTED OR STEPCHILDREN?_____

ANY MISCARRIAGES, ABORTIONS, OR TUBAL PREGNANCIES?_____

SURGERIES AND HOSPITALIZATIONS (PLEASE DO NOT INCLUDE CHILDBIRTH)

YEAR	*OPERATION*	*HOSPITAL*	*SURGEON*

_____

_____

_____

ANY OTHER PROBLEMS OR CONCERNS? YES NO

_____

PATIENT SIGNATURE: _____ DATE: _____