MEDICAL HISTORY FORM

Bladder Health:

Do you ever leak urine when you cough, laugh, sneeze, or exercise? YES / NO
Do you ever leak urine on the way to the bathroom or cant get to the bathroom on time? YES / NO
Do you have a history of recurrent urinary tract infections? YES / NO
Do you go to the bathroom frequently and/or get up multiple times at night? YES / NO

Surgical History:

_____ No Surgical History
_____Hysterectomy
_____Appendectomy
_____Kidney Surgery
_____Back Surgery
_____Left Ovary Removal
_____Heart Surgery
_____Hernia Repair
_____Tubal Ligation
_____Uterine Ablation
_____Bladder Sling
_____Right Ovary Removal
______ Oral Surgery
______Sinus Surgery
______Cholecystectomy
______Dilation and Curettage
______Leep
______Fumigation of Endometriosis

Family Medical History:

_____ No Family Medical History to Report
_____Breast Cancer
_____Hypertension
_____Colon Cancer
_____Mental Illness
_____Heart Disease
______Uterine Cancer
______Kidney Disease
______Thyroid Disorder
______Auto Immune Disorders
______Stroke
_____Cervical Cancer
_____Diabetes
_____Osteoporosis
_____Bleeding Disorder
_____Other:_________

Social History:

Tobacco Use: Yes/No
At what Age did you start: _________
Type of product used: ______Cigarettes ______E-cigarettes ____Vape ______Chewing Tobacco
Amount of use: ______Daily ______Some days, but not every day ______5 or less
Former Smoker --- Age you stopped smoking? _______

Alcohol use: Yes/No
Have you drank alcohol in the last year? _______
How often do you drink alcohol? ______Daily ____Socially ____Occasionally ______Never

Recreational Drugs: Yes/No
Type of use: __________________________
How often do you use:_________________

Domestic Abuse:
Are you currently experiencing any type of abuse? YES / NO
Type of Abuse : ______Verbal ______Physical ______Sexual

OTHER:
Would you object to blood products in the event of an emergency? YES / NO

MEDICAL HISTORY FORM

Name: ___________________________________ DOB: _______________

REASON FOR VISIT: ____ Annual (pap smear/yearly) _____ Problem

Current Medication: (If copy of list, please make copy)

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

Patient History:

Date of last pap smear & result: ___________________________

Date of last mammogram & result: ___________________________

Date of last Colonoscopy & result: ___________________________

Date of last Bone Density & result: ___________________________

_____ No Medical Problems to report.

_____Diabetes

_____Cancer

_____Mental Health Disorder

_____Heart Disease

_____Hypertension

_____Blood/Clotting Disorders

_____Endocrine Disorder

_____Liver Disease

_____Kidney Disease

_____Sexually Transmitted Disease

_____Abnormal pap smear

Allergies:

____ No Known Allergies

____Latex ____Penicillin ____Lidocaine

____Epinephrine ____Sulfa ____IVP Dye

Please list any other allergies: ____

Reproductive History:

Last LMP: ____________ Age of first Menstrual Cycle: _____ Menstrual Flow: __________

Birth Control Method: (Please circle)

Nothing Withdrawal Condoms Diaphragm Oral Contraceptives Contraceptive Patch

Contraceptive Vaginal Ring Depo Provera Nexplanon IUD Tubal Ligation Vasectomy Hysterectomy

If IUD/Nexplanon please write the date of insertion: ___________________________________

Pregnancy History

Total Preg._____Full Term_____Premature_____Miscarriages____Abortions_____Ectopic_____Living Children____

Menopausal Status: _______________