

(Please complete both sides)

Name _____ Age _____ Date of Birth _____
 Marital Status _____ Spouse's Name _____ Religion _____ Race _____

FAMILY HISTORY		PAST SURGICAL HISTORY		
Has anyone in your family (NOT yourself) had:		Operations? (list)		
		What	Where	When
272.0 - Elev. cholesterol...	NO YES-who? _____			
v16.41 - Ovarian Cancer...	NO YES-who? _____			
v16.3 - Breast Cancer	NO YES-who? _____			
v16.9 - Other Cancer	NO YES-who? _____			
v17.6 - Lung Disease	NO YES-who? _____			
v18.0 - Diabetes	NO YES-who? _____			
v19.8 - Twins	NO YES-who? _____			
v17.4 - High Blood Pressure ...	NO YES-who? _____			
v18.3 - Bleeding Tendency	NO YES-who? _____			
v17.0 - Mental Illness	NO YES-who? _____			
v17.0 - Suicide	NO YES-who? _____			

ALLERGIES and SENSITIVITIES (Patient Check List)

Have you ever had a "reaction" (such as blisters, hives, reddening of the skin, asthma or hayfever, etc.) to any of the following?

1) v14.0 - Penicillin or other antibiotics.....NO	YES (Specify)? _____
2) v14.5 - Morphine, codeine, demerol.....NO	YES (Specify)? _____
3) v14.4 - Novocaine or other anesth	YES (Specify)? _____
4) v14.6 - Aspirin or other pain med	YES (Specify)? _____
5) v14.2 - Sulfa Drugs	YES (Specify)? _____
6) v14.8 - Tetanus or other serum	YES (Specify)? _____
7) 629.9 - Adhesive tape, latex or other "Contact" substance	NO YES (Specify)? _____
8) v14.3 - Iodine, merthiolate, etc	NO YES (Specify)? _____
9) 995.27 - Any other drug or med.....NO	YES (Specify)? _____
10) v15.5 - Any foods, such as eggs, milk, chocolate, strawberries, etc.....NO	YES (Specify)? _____

TRANSFUSIONS

Have you ever had a transfusion?NO YES When? _____

PRIOR NON-GYN ILLNESSES/CHRONIC CONDITIONS (eg. Diabetes, Breast Cancer, etc.)

1) _____
 2) _____
 3) _____
 4) _____
 5) _____

PREGNANCIES

List in order (include miscarriages, ectopic & abortions)

DATE	SEX	WEIGHT	COMPLICATIONS (C-sections, etc)

SIGNIFICANT PAST GYN ISSUES (Abnormal Paps, Cysts, Bleeding, etc)

Do not list today's problems.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Please circle YES or NO next to each question below:

SKIN:

Bruise easily?NO YES
Have prolonged bleeding from cuts?NO YES
Have a sore that doesn't heal?NO YES
Ever had blood clots (in legs)?NO YES

EYES:

Wear glasses?NO YES
Have blurred Vision?NO YES
See double?NO YES
See spots or halos around lights?NO YES

EARS:

Difficulty hearing?NO YES
Ringing in ears?NO YES
Frequent dizzy spells?NO YES

NOSE, MOUTH, THROAT:

Frequent nose bleeds?NO YES
Wear dentures?NO YES
Sore, sensitive, or bleeding gums?NO YES
Frequent sore throats?NO YES
Hay fever or allergies?NO YES

CHEST:

Ever had high blood pressure?NO YES
Heart trouble or murmur?NO YES
Severe shortness of breath?NO YES
Chronic cough?NO YES
Ever cough up blood?NO YES
Ankle swelling?NO YES
Heart often skip a beat or race?NO YES
Heart pain?NO YES

GASTROINTESTINAL:

Recent change in appetite?NO YES
Chronic constipation or diarrhea?NO YES
Recent change in bowel habits?NO YES
Bloody or tarry stools?NO YES
Thirst you can't satisfy?NO YES

URINARY TRACT:

Ever had a kidney or bladder infection?NO YES
Have pain, urgency or burning with urination?NO YES
Passed blood in urine?NO YES
Ever had sugar in urine?NO YES

NEUROMUSCULAR:

Ever had a convulsion?NO YES
Ever had swollen, red or stiff joints?NO YES
Have paralysis or deformity?NO YES

ENDOCRINE:

Unduly sensitive to heat or cold?NO YES
Any thyroid trouble?NO YES
Ever been told you are diabetic?NO YES
Has your weight varied over 10# in last year?NO YES

PERSONAL HISTORY:

Marital Status? _____
If married how long? _____
If divorced, how long? _____
Is your marriage satisfactory?NO YES
Are you unusually depressed lately?NO YES
Any special problems worrying you?NO YES
Do you smoke?NO YES
If yes, specify? _____
Do you drink?NO YES
If yes, # drinks per week? _____
Are you presently taking any type of medication?
NO YES

If so, List: _____

Section Reserved for Physician Notes