

(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
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 anesthNO	YES (Specify)? _____
4) v14.6 - Aspirin or other pain medNO	YES (Specify)? _____
5) v14.2 - Sulfa DrugsNO	YES (Specify)? _____
6) v14.8 - Tetanus or other serumNO	YES (Specify)? _____
7) 629.9 - Adhesive tape, latex or other "Contact" substanceNO	YES (Specify)? _____
8) v14.3 - Iodine, merthiolate, etcNO	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

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

EYES:

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

NEUROMUSCULAR:

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

EARS:

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

ENDOCRINE:

Unduly sensitive to heart 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

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

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: _____

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

Section Reserved for Physician Notes

PATIENT SIGNATURE: _____

DATE: _____