

PATIENT HISTORY

I. Identifying Information

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Present Employment (title/brief description) \_\_\_\_\_  
Marital Status \_\_\_\_\_ Ethnic Background \_\_\_\_\_ Religion \_\_\_\_\_  
What is the reason for your visit?  
\_\_\_\_\_

II. Medical History

Blood Type (if known) \_\_\_\_\_ Have you gained or lost greater than 20 pounds in the last year?  YES  NO  
Have you ever had pelvic surgery?  YES  NO  
If yes, specify date and type  
\_\_\_\_\_

Do you have or have you ever had (check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Gallbladder Problems           | <input type="checkbox"/> Palpitations           |
| <input type="checkbox"/> Appendicitis           | <input type="checkbox"/> Goiter                         | <input type="checkbox"/> Pelvic Infection       |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Gonorrhea                      | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Blood Transfusions     | <input type="checkbox"/> Hair Loss                      | <input type="checkbox"/> Poor Sense of Smell    |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Breast Soreness        | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Skin Changes           |
| <input type="checkbox"/> Breast Tenderness      | <input type="checkbox"/> Herpes                         | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Cancer? Specify _____  | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Syphilis               |
| _____   | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Chlamydia              | <input type="checkbox"/> Immunization: German Measles   | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Chronic Fatigue        | <input type="checkbox"/> Kidney Infection               | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Chronic Headaches      | <input type="checkbox"/> Liver Problems                 | <input type="checkbox"/> Vaginitis              |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Loss of Balance                | <input type="checkbox"/> # of episodes _____    |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> German Measles                 | <input type="checkbox"/> Visual Disturbances    |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Neurological Problems          | <input type="checkbox"/> Allergies? List: _____ |
| <input type="checkbox"/> Endometriosis          | <input type="checkbox"/> Nongonococcal Urethritis       | _____   |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Ovarian Cysts                  | _____   |

Please specify any other medical condition(s) for which you have been treated:  
\_\_\_\_\_  
\_\_\_\_\_

Within the last year, have you taken any prescription medications?  YES  NO

If yes, list all medications and diagnoses:  
\_\_\_\_\_  
\_\_\_\_\_

Within the last year, have you taken any over-the-counter medications on a regular basis?  YES  NO

If yes, list all medications and diagnoses: \_\_\_\_\_

Do you use or have you ever used (check all that apply):

- Alcohol - How many glasses per week do you usually drink? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_
- Cigarettes - number of packs per day \_\_\_\_\_
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify \_\_\_\_\_

### III. Obstetrical and Gynecological History

Age at first period \_\_\_\_\_ When was your last period? \_\_\_\_\_

Are your periods regular?  YES  NO

If yes, what is the usual number of days from the beginning of one period to the beginning of the next? \_\_\_\_\_

If no, how many times per year do you menstruate? \_\_\_\_\_ What is the usual duration of your period? \_\_\_\_\_

Do you use  pads or  tampons? How many pads or tampons do you use on your heaviest day? \_\_\_\_\_

Are cramps present before, during, or after your period? \_\_\_\_\_ Are cramps:  Mild  Moderate  Severe?

Do you have to take pain medications for cramps?  YES  NO If yes, specify medications \_\_\_\_\_

Do you bleed or spot between periods?  YES  NO

How many pregnancies (including miscarriages and abortions) have you had?

	When End in (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required?	How long to conceive?	Baby Born Alive?	Current Partner the Father?
1 <sup>st</sup> Pregnancy								
2 <sup>nd</sup> Pregnancy								
3 <sup>rd</sup> Pregnancy								
4 <sup>th</sup> Pregnancy								
5 <sup>th</sup> Pregnancy								

Were there any complications during or after your pregnancies?  YES  NO

If yes, explain:

\_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_ Any abnormal pap smears?  YES  NO If yes, give dates: \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_ Date of last Bone Scan \_\_\_\_\_ Do you Douche?  YES  NO

Age at Menopause \_\_\_\_\_ Are you currently using Hormone Replacement Therapy?  YES  NO

Have you used Hormone Replacement Therapy in the past?  YES  NO

If yes, what is the total amount of time you used these medications? Years \_\_\_\_\_ Months \_\_\_\_\_

### IV. Contraceptive/Sexual History

Age at first sexual intercourse \_\_\_\_\_ Is intercourse difficult or painful for you?  YES  NO

What form of contraception do you use now or have you used in the past? Check all that apply:

Pills (name) \_\_\_\_\_  IUD (name) \_\_\_\_\_  Diaphragm  Withdrawal

Foams/Jellies  Condom  Rhythm  None  Other: \_\_\_\_\_

For each contraceptive used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have ever been on oral contraceptives (pills), were your periods regular after stopping the pills?  YES  NO

I CERTIFY that the above medical information is true to the best of my knowledge and I give consent to Dr. Martin E. Kanoff and/or his designee for necessary treatment when indicated.

SIGNED \_\_\_\_\_