ADVANTIA HEALTH

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New Patient Medical History

Appointment Date: ____/____/____
Patient name: Last_____First_____Birth Date: ____/____/____
Occupation: _____Age: _____
Current City/Town: _____ Current Zip Code: _____Primary Language: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Living with partner

School completed: ☐High school ☐College ☐Graduate degree ☐Other: _____

Ethnicity: ☐Caucasian ☐African American ☐Hispanic ☐North Asian
☐South Asian ☐Pacific Islander ☐Native American ☐Other: _____

Main support person(spouse, partner, etc.): _____Relationship of main support person: _____
Occupation of main support person: _____Telephone number of main support person: _____

Referring Physician: _____ Referring Physician: _____
Address: _____ Address: _____
_____ _____
_____ _____
Phone #: _____ Phone #: _____

History of Present Illness

Please briefly describe the nature of the problem that brought you to our clinic:

_____
_____

Have you seen any other physicians for this problem? If yes, please list the physician and any evaluation or therapy.

_____

When did this problem start? _____
What have you tried for relief? _____
What makes the problem better? _____
Does anything worsen the problem? _____
How severe is the problem now? _____

Urogynecology History

Genitourinary

1. In a typical day, how many times do you urinate? (***frequency***) _____
2. In a typical night, how many times do you awaken to urinate?: (***nocturia***) _____
3. Do you leak urine when you do not want to (***stress incontinence***)?: ☐No ☐Yes
   If yes, check any conditions that cause you to leak:
   3a. ☐Coughing ☐Sneezing ☐Laughing ☐Exercise ☐Upon standing ☐Housework ☐Lifting ☐Intercourse
4. In a typical day, do you experience frequent, strong urges to urinate?: (***urgency***) ☐No ☐Yes
   4a. *If yes, do you leak urine during these strong urges: (**urge incontinence**)* ☐No ☐Yes

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(Urogynecology History Continued)

5. In a typical week, do you have **difficulty emptying your bladder**? ☐No ☐Yes
6. Do you wear **pads**: ☐No ☐Yes
   6a. *If yes, how many pads do you wear per day?* _____
7. How much do you drink in a typical day? (***fluid intake***) _____
8. Please list any **overactive bladder medicines** you have tried and how long did you use them? _____

_____

Gastrointestinal

9. In a typical week, how many **bowel movements** do you have? _____
10. In a typical week, how many **laxatives** do you use? _____
11. In a typical week, do you have **difficulty having bowel movements**?: ☐No ☐Yes
12. In a typical week, do you **leak stool** when you do not want to?: (***fecal incontinence***) ☐No ☐Yes
13. In a typical week, do you **leak gas** when you do not want to?: (***flatal incontinence***) ☐No ☐Yes

Gynecologic

14. Do you feel that your bladder, uterus, vagina or rectum are **falling out**?: (***prolapse***) ☐No ☐Yes
15. Are you currently **sexually active**? ☐No ☐Yes
16. Do you have any **physical problems** with sexual relations? ☐No ☐Yes
17. Do you have **pain** with sexual intercourse? (***dyspareunia***) ☐No ☐Yes

Cancer Screening

Date of last pap smear: ___/___ Was it: normal / abnormal History of abnormal pap smears? ☐No ☐Yes
If abnormal or history of abnormal paps, please explain: _____
Date of last mammogram: ___/___ Was it: normal / abnormal History of abnormal mammograms? ☐No ☐Yes
If yes, please explain: _____
Date of last colonoscopy: ___/___ Was it: normal / abnormal History of abnormal colonoscopies? ☐No ☐Yes
If yes, please explain: _____
Have you received a Cervical Cancer Vaccination? ☐No ☐Yes If yes, please give the date: _____

Allergies

(Please list any drug allergies)

Medication	Reaction	Medication	Reaction

Medications

(Please list any over the counter medications in addition to prescribed medicines)

Medication	Reaction	Medication	Reaction

(Continue on back if needed)

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Past Medical History

(Please check any medical problems you were diagnosed with as an adult)

- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ COPD
- ☐ Cancer _____
- ☐ Heart attack
- ☐ Stroke
- ☐ Blood clots (DVT, etc.)
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Heart murmur
- ☐ Thyroid disease
- ☐ Lupus
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Pelvic radiation for cancer
- ☐ Bladder cancer

Serious injuries (Please explain): _____

Procedures to your cervix (Conization, LEEP, etc.). Please list procedure, reason for procedure and date of procedure: _____

Other Medical Diagnoses (please list)	Date of Diagnosis	Treating Physician

Past Surgical History

(Please list any previous surgeries/operations)

Hysterectomy Date of Operation _____

Please check the type of hysterectomy ☐Abdominal incision ☐Laparoscopic ☐Vaginal ☐Supracervical
☐Both ovaries were removed ☐Right ovary was removed ☐Left ovary was removed

Reason for surgery: _____

Any other procedures performed during surgery: _____

Removal of ovaries as a separate surgery Date of Operation _____

Please check the type of surgery
☐Laparoscopy ☐Abdominal incision ☐Both ovaries were removed ☐Right was removed ☐Left was removed

Reason for surgery: _____

Any other procedures performed during surgery: _____

Other Gynecologic surgeries

- ☐ Tubal ligation — Reason and date of surgery: _____
- ☐ Laparoscopy — Reason and date of surgery: _____
- ☐ Exploratory laparotomy — Reason and date of surgery: _____
- ☐ **Vaginal suspension** — Reason and date of surgery: _____
- ☐ **Cystocele repair** — Reason and date of surgery: _____
- ☐ **Rectocele repair** — Reason and date of surgery: _____
- ☐ **Bladder tack** — Reason and date of surgery: _____
- ☐ **Incontinence surgery**
  - ☐ Suburethral Sling — Reason and date of surgery: _____
  - ☐ Burch — Reason and date of surgery: _____
  - ☐ MMK — Reason and date of surgery: _____
  - ☐ Collagen — Reason and date of surgery: _____
- ☐ **Other Abdominal surgeries**
  - ☐ Appendectomy — Reason and date of surgery: _____
  - ☐ Gallbladder removal — Reason and date of surgery: _____
  - ☐ Bowel surgery — Reason and date of surgery: _____

Other Surgeries or Hospitalizations (Please list)	Date	Hospital

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Obstetrical History

Please list number of:
Pregnancies (All pregnancies) _____ Miscarriages_____ Abortions_____ Living Children_____

No	Birth Date	Birth Weight	Male/Female	Weeks/Months of pregnancy	Type of Delivery	Tears into Rectum
1	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes
2	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes
3	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes
4	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes
5	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes
6	__/__/__	_____	M / F	_____ weeks/months	Vaginal / C section / Vacuum / Forceps	☐No ☐Yes

(Continue on back if needed)

Gynecology History

Menstrual History

How old were you when you had your first period? _____
Age of menopause (if applicable): _____
If abnormal cycles, please explain: _____

First day of last menstrual cycle: ____/____/____
How often do you have a menstrual cycle: _____
Length of bleeding: _____

Sexual History

If you are sexually active, what birth control (if any) do you use?: ☐None ☐ Pill ☐Patch or ring ☐Depo Provera (shot)
☐IUD ☐Condoms ☐Rhythm method ☐Tubal ligation ☐Partner has vasectomy ☐Other _____
History of sexually transmitted diseases?: ☐No ☐Yes If yes, please explain: _____

Social History

1. Do you smoke currently? ☐No ☐Yes
2. Did you smoke in the past? ☐No ☐Yes
3. Do you drink alcohol? ☐No ☐Yes
4. Do you use any street drugs? ☐No ☐Yes
5. Do you exercise regularly? ☐No ☐Yes
6. Do you drink caffeine? ☐No ☐Yes

If yes: _____# packs per day for _____ years
If yes, when did you quit? _____
If yes, how much: _____
If yes, please explain: _____
If yes, please describe: _____
If yes, please describe: _____

Family History

Has anyone in your family had any of these diseases? If so, please give relationship to you.

1. Breast cancer: _____ 2. Heart disease: _____
3. Ovarian cancer: _____ 4. Colon cancer: _____
5. Prolapse (including cystocele or rectocele): _____
6. Urinary Incontinence: _____
7. Other disease(s), please list: _____

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Review of Systems

In the past **7 days**, have you been bothered by any of the symptoms below?

Constitutional:	☐ Fever ☐ Loss of appetite	☐ Fatigue	☐ Weight change
Eyes:	☐ Eye pain	☐ Blurry vision	☐ Loss of vision
ENMT:	☐ Swollen neck glands	☐ Loss of hearing	
Cardiovascular:	☐ Chest pain ☐ Fainting (syncope)	☐ Heart palpitations ☐ Heart murmur	☐ Leg swelling
Respiratory:	☐ Shortness of breath	☐ Wheezing	☐ Frequent coughing
Gastrointestinal:	☐ Abdominal pain ☐ Blood in stool ☐ Decreased appetite	☐ Constipation ☐ Vomiting	☐ Diarrhea ☐ Nausea
Genitourinary:	☐ Abnormally heavy bleeding ☐ Painful intercourse ☐ Urinary urgency ☐ Painful urination	☐ Irregular menstrual cycles ☐ Abnormal discharge ☐ Urinary frequency ☐ Blood in urine	
Musculoskeletal:	☐ Joint pain ☐ Difficulty walking	☐ Joint stiffness ☐ Muscle pain	☐ Back pain ☐ Muscle weakness
Neurological:	☐ Frequent headaches	☐ Frequent dizziness	☐ Seizures
Skin:	☐ Rash	☐ Itching	
Breast:	☐ Breast mass	☐ Breast pain	☐ Nipple discharge
Psychiatric:	☐ Depression	☐ Anxiety	☐ Memory loss or confusion
Endocrine:	☐ Diabetes	☐ Hyperthyroidism	☐ Hypothyroidism