Date_______________

PATIENT DATA SHEET

Name:____Age:________________

Referred By:_____________________________

PROBLEMS AND REASON FOR VISIT:

Have you consulted anyone for this?____
Who? (Name and Address)____
When? (Dates of treatment)____
Describe previous treatment:

Date of last period______________
Date of last Pap smear___________

GYN SYSTEM REVIEW:

Menses: Age at onset of period:__________
Irregular_________Regular__________
How often do you get your period? (Check appropriate one below).
Less than 20 days apart _____ 21-30 days apart _____ 30-40 days apart ____ Greater than 40 days apart_____
How many days do your periods generally last? (Check appropriate one below).
Less than 2 ____ 2-5 _____ 5-7 _____ 7-10 _____ Greater than 10 _____
How many pads/tampons do you use on the heaviest days? ______

	Yes	No
Any clots?	____	____
How large?	____	____
Do you have to stay in bed on the heavy days?	____	____
Do you miss work or school regularly each month?	____	____
If yes, how many days? _________		
Any bleeding or spotting between periods?	____	___
Any bleeding or spotting after intercourse?	____	____
Any abnormal Pap smears?	____	____
If menopausal, have you ever been on hormone replacement therapy?	____	____

PAIN:

	Yes	No
Do you have any significant pain with periods?	____	____
Do you take any medication to relieve it regularly?	____	____
Do you have any lower abdominal pain at other times of the month?	____	____
Do you have pain during or after intercourse?	____	____
Do you have frequent headaches?	____	____

If yes to any of the above:
Describe location, character, radiation or distribution, frequency and duration of any of the above answers:

DISCHARGE:

	Yes	No
Do you have any chronic or persistent discharge?	____	___
What color is it? ____________________		
Does it have a bad odor?	____	____
Have you had itching?	____	____
Do you wear a pad for it?	____	____

	Yes	No
Do you douche?…………	____	____
If yes, how often?________________________		
What do you use: ________________________		
Have you been treated for vaginitis before?…………	____	____
How many times?_________________		
Do you know what type? Trichomonas _______Yeast ________Non-Specific _______		
When were you last treated? _________________		
What treatment did you receive? ____		

G.U.

Do you have or have you had recently:	Yes	No
Burning on urination…………	____	____
Blood in urine…………	____	____
Undue frequency…………	____	____
Urgency about urination…………	____	____
Do you get up at night to urinate?…………	____	____
How many times? ____________		
Do you wet yourself involuntarily with any of the following:		
Coughing, sneezing, laughing, running, lifting or going up or down stairs? …………	____	____
Do you have to wear a pad for protection: …………	____	____
How often do you have to change your pad/day? ___________		
Do you have a weak stream? …………	____	____
Have you had any bladder or kidney infections? …………	____	____
How many time? _________ When was the last one?__________		
Have you ever had kidney X-rays/ultrasounds? …………	____	____
Have you ever seen a urologist? …………	____	____

G.I.

Are you chronically constipated? …………	____	____
Any change in bowel habit? …………	____	____
Do you take laxatives? …………	____	____
How often? _____________		
Do you have any blood in stools? …………	____	____
Do you have frequent or chronic diarrhea? …………	____	____
Any known ulcer? …………	____	____
Any know gall bladder disease? …………	____	____
Any known intestinal or stomach disorder? …………	___ _	____

OTHER:

Have you had any of the following?		
Shortness of breath …………	____	____
Dizziness …………	____	____
Palpitations …………	____	____
Breast masses or lumps…………	____	____
Nipple discharge..…………	____	____
Problem with sexual function.…………	____	____

	Yes	No
Do you now or have you ever smoked cigarettes? …………	____	____
# Cigarettes / Day _______ Age when started? _______ Age when quit? ______		
Do you drink alcoholic beverages? …………	____	____
How much/day _____________ Have you ever drunk heavily? …………	____	____
Do you use recreational drugs; marijuana, cocaine, etc. …………	____	____

BIRTH CONTROL:

Method	Brand Name	Dates of Usage	Reason for Discontinuation
Birth Control Pills			
Depo Provera			
IUD			
Diaphragm			
Foam			
Condoms/Vasectomy			
Tubal ligation			
Other			

MEDICAL HISTORY: (If yes, where you are/were treated and by whom beside each section)

Have you had:	**Yes**	**No**
Anemia …………	____	____
Arthritis …………	____	____
Asthma/Lung Disease/COPD …………	____	____
Back Pain …………	____	____
Bleeding Tendencies …………	____	____
Blood Transfusion…………	____	____
Cancer (Type)…………	____	____
Chemotherapy …………	____	____
Chronic Kidney Disease …………	____	____
Diabetes …………	____	____
Diverticulosis/Diverticulitis…………	____	____
Epilepsy …………	____	____
Eye, Ear, Nose or Throat Problems …………	____	____
German Measles …………	____	____
Heart Disease …………	____	____
Hepatitis …………	____	____
High Blood Pressure …………	____	____
High Cholesterol …………	____	____
Migraine Headaches…………	____	____
Mitral Valve Prolapse …………	____	____
Neurological Problems (e.g. Alzheimer's, Multiple Sclerosis) …………	____	____
Phlebitis (Blood Clots) …………	____	____
Pneumonia …………	____	____
Psychiatric Illness …………	____	____
Radiation Therapy …………	____	____
Rheumatic Fever …………	____	____
Rheumatic Heart Disease …………	____	____
Severe Depression …………	____	____
Sexually Transmitted Diseases …………	____	____
Stroke or TIA…………	____	____
Thyroid Disease …………	____	____
Tuberculosis …………	____	____
Ulcers (gastric, duodenal, esophageal)…………	____	____
Venereal Disease …………	____	____
Other …………	____	____

SURGICAL : List any surgical procedures you have had in your lifetime:

Date	Procedure	Hospital	Location	Surgeon

Have you been hospitalized for anything else not discussed?

Date	Hospital	Reason For Admission	Duration of Stay

OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions and/or complications.

MISCARRIAGES:

Date	Length of Pregnancy	D& C	Complications	Location

ABORTIONS:

Date	Length of Pregnancy	D & C	Complications	Location

DELIVERIES:

Date	Wt Gain	Length of Labor	Anesthesia	Natural? Forceps? C-Section?	Sex	Wt	Complications

IMMUNIZATIONS: **Yes** **No**

Have you ever had a TB skin test? ……………………………………………………………… …. ____ ____

If yes, when was it last done? ________________ Results_________________

When was your last tetanus booster?_________________

Have you had a vaccination for hepatitis?…………………………………………………………… ____ ____

Have you had an influenza vaccination?.…………………………………………………………. ____ ____

Have you had an pneumonia vaccination?………………………………………………………... ____ ____

ALLERGIES:

	Yes	No
Are you allergic to any drugs or medications?…………………………………………………………..	____	____

If yes, please list:

Drug	Type of Reaction

MEDICATIONS:

List all medications presently being taken, if any. (Include oral contraceptives).

Drug/Dosage	Indication	How long taken	Side Effects

FAMILY HISTORY:

	Age	State of Health	Specific Ailments	If Deceased, Age at Death & Cause
Mother				
Father				
Brother				
Brother				
Sister				
Sister				

Any of the following in grandparents, uncles, aunts or relatives:

Breast cancer______________________ Uterine Cancer___________________ Ovarian Cancer_________________

Endometriosis_______________________Fibroids__________________ Thyroid Disease______________________

Rectal/Colon Cancer_______________________Other Cancers____

Diabetes________________________________High Blood Pressure_______________________________________

Heart Attack___________________________________ Other Heart Disease________________________________

Stroke_____________________ Pulmonary Embolism/Deep Venous Thrombosis_____________________________

Neurologic Problems (e.g. Alzheimer’s, Multiple Sclerosis, Epilepsy)________________________________

Psychiatric Disease________________________________Alcoholism______________________________________

Other Familial Diseases____

SOCIAL HISTORY:

Birthplace___________________________________Marital Status_________________________

Ethnic Background_________________________________Religious Affiliation_______________

Education____

Work experience____