Lincoln Park GYN
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NAME _____ **DATE** _____

CHIEF COMPAINT: _____

_____

MEDICAL HISTORY:

_____ Allergies _____ High Blood Pressure _____ Depression/ Bipolar Disease

_____Asthma _____ Thyroid Problems _____ Seizure Disorder

_____ Anemia _____ Liver Disease _____ Hepatitis

_____ Breast Problems _____ Kidney or Bladder Problems _____ HIV (AIDS)

_____ Diabetes _____ Stomach/ Digestive Problems _____ Blood Disorder

_____ Heart Disease _____ Cancer _____ High Cholesterol _____ Infertility

Other: _____

_____

Hospitalizations & Surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current Medications:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Allergies: _____

SOCIAL HISTORY: **(indicate how often):** Smoking _____ Alcohol _____Drugs_____ Exercise_____

OCCUPATION: _____

FAMILY HISTORY: (heart disease, diabetes, high blood pressure, breast disease, cancer)

_____

_____

GYNECOLOGICAL HISTORY: (Please indicate if "YES' or "NO" along with dates and duration of all that apply):

Abnormal Menstrual Bleeding _____ Heavy Periods? YES NO

Abnormal Pap Smear _____

Abnormal Mammogram _____

Abnormal Vaginal Discharge _____

History of Sexually Transmitted Diseases (STD) _____

Problems with Sexual Function _____

OBSTETRICAL HISTORY:

Have you ever been pregnant? _____ How many living children: _____

Delivery by: C-Section _____ Vaginal Birth _____

Are you planning on having another child in the future? YES NO MAYBE

URINARY / BLADDER:

History of Bladder Infections? _____ Burning? _____ Frequency? _____ Urgency? _____

Loss of Urine when: Sneezing? _____ Coughing? _____ Running? _____

IF OVER 50 YEARS OF AGE OR MENOPAUSED:

Do you experience hot flashed? _____

Problems with Sexual Function? _____

Vaginal Dryness? _____

Date and Result of last Colonoscopy? _____

Date and Result of Last Bone Scan? _____

Do you Exercise? _____ If so, how often? _____

Do you take calcium and Vitamin D Supplements? _____ If so, how much? _____

Age _____ Weight _____ Age at Menopause _____

Smoking? _____ Alcohol Intake? _____ (specify number of drinks per day)

History of Bone Fracture _____ Family History of Hip Fracture? _____