Main Line HealthCare
Physician Network

MEDICAL AND GYNECOLOGIC HISTORY

DATE:_____ **NAME**:_____ **DOB**:_____

REVIEWED WITH PATIENT
❒ **DR. DUNTON** ❒ **DR. HOLTZ** ❒ **DR. STAMPLER** ❒ **DR. STICKLES** ❒ **DR. WANG**

CURRENT GYNECOLOGIC PROBLEM OR REASON FOR CONSULTATION:

_____

Date of last menstrual period_____ Age at first period_____ Menopause age (if applies)_____

Days between periods_____ How long do your periods last _____

How many pregnancies_____ How many deliveries _____How many miscarriages/terminations _____

Bleeding between periods? ❒ Yes ❒ No

Painful periods? ❒ Yes ❒ No

Pre-menstrual syndromes? ❒ Yes ❒ No

Bleeding with intercourse? ❒ Yes ❒ No ❒ N/A

Pain with intercourse? ❒ Yes ❒ No ❒ N/A

Did your mother take DES when pregnant with you? ❒ Yes ❒ No

Are you sexually active? ❒Yes ❒ No If yes, method of contraception _____

Is your current partner? ❒Male ❒ Female ❒ Both

Have you received the HPV vaccine? ❒Yes ❒ No

History of sexually transmitted disease (i.e. gonorrhea, chlamydia, herpes, syphilis)? ❒Yes ❒ No

Date of last PAP Smear _____

Have you ever had an abnormal PAP Smear? ❒Yes ❒ No

If yes, when and how was it treated? _____

Have you ever taken hormone replacement therapy? ❒Yes ❒ No

Date of last mammogram _____Date of last DEXA_____Date of colorectal screening_____

ALLERGIES TO MEDICATIONS/FOODS

ALLERGY	REACTION
1.	
2.	
3.	

NAME:_____ **DOB**:_____

MEDICAL PROBLEMS:

Kidney Disease ❒ Yes ❒ No

Lung Disease ❒ Yes ❒ No

Heart Disease (i.e. heart attack, irregular heart rate, heart failure, pacemaker) ❒ Yes ❒ No

Lung Disease (i.e. asthma, COPD) ❒Yes ❒ No

High Blood Pressure ❒Yes ❒ No

Liver Problems (i.e. hepatitis) ❒ Yes ❒ No

Blood clots ❒Yes ❒ No

Cancer ❒ Yes ❒ No If yes, what kind and treatment received? _____

Thyroid ❒ Yes ❒ No

Sleep Apnea ❒ Yes ❒ No If yes, do you use CPAP or BIPAP? ❒ Yes ❒ No

Anemia ❒ Yes ❒ No

HIV/AIDS ❒Yes ❒ No

Gastrointestinal Problems (i.e. ulcer, acid reflux, Crohns disease, celiac) ❒Yes ❒ No

Infections such as MRSA, C.difficile ❒ Yes ❒ No

Bleeding or Blood Clotting Disorder ❒Yes ❒ No

Other _____

PAST SURGERIES OR HOSPITALIZATIONS (other than current illness):

Dates Hospital Procedure

_____

_____

_____

_____

HABITS:

Tobacco ❒ Yes ❒No ❒ Quit number of packs/day_____ number of years_____

Drugs ❒ Yes ❒No ❒ Quit

Alcohol ❒ Yes ❒ No ❒ Quit number of drinks per day/week_____

Exercise ❒ Yes ❒ No number of days per week_____

OCCUPATION:_____

MARITAL STATUS: ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Separated ❒ Long term relationship

FAMILY HISTORY:

Do any family members (including aunts, uncles, cousins, nieces, nephews) have?

❒ Breast cancer ❒ Ovarian cancer ❒ Colon cancer ❒ Uterine cancer

Is there a family history of: ❒ Diabetes ❒ Heart Disease ❒ Blood clots/bleeding disorder

OTHER FAMILY HISTORY:_____

NAME:_____ **DOB**:_____

REVIEW OF SYSTEMS

BREAST EVALUATION:			
Breast exams monthly?	❒ Yes ❒ No (If no, please ask for information)		
Any previous abnormalities or recent changes?	❒ Yes ❒ No	Previous biopsies?	❒ Yes ❒ No
LUNGS:			
Do you have a chronic cough?	❒ Yes ❒ No	Pneumonia?	❒ Yes ❒ No
Coughing blood?	❒ Yes ❒ No	Tuberculosis?	❒ Yes ❒ No
Wheezing?	❒ Yes ❒ No	Snoring?	❒ Yes ❒ No
Heart:			
Shortness of breath?	❒ Yes ❒ No	Rheumatic fever?	❒ Yes ❒ No
Chest pain?	❒ Yes ❒ No	Swelling of legs?	❒ Yes ❒ No
Palpitations of the heart?	❒ Yes ❒ No	Mitral valve prolapse?	❒ Yes ❒ No
Awake from sleep with shortness of breath?	❒ Yes ❒ No		
INTESTINAL FUNCTION:			
Pain or bleeding with defecation?	❒ Yes ❒ No	Diarrhea?	❒ Yes ❒ No
Thinning of stools?	❒ Yes ❒ No	Constipation?	❒ Yes ❒ No
Indigestion/heartburn?	❒ Yes ❒ No	Nausea/vomiting?	❒ Yes ❒ No
Bloating?	❒ Yes ❒ No		
BLADDER FUNCTION:			
Pain or bleeding with urination?	❒ Yes ❒ No	Involuntary loss of urine?	❒ Yes ❒ No
Empty bladder incompletely?	❒ Yes ❒ No	Pressure on bladder?	❒ Yes ❒ No
ANY SKIN LESIONS OR DISEASE?	❒ Yes	❒ No	
NEUROLOGIC:			
Seizures?	❒ Yes ❒ No	Loss of consciousness?	❒ Yes ❒ No
Nerve loss or injury?	❒ Yes ❒ No	Stroke or "mini" stroke ?	❒ Yes ❒ No
GENERAL MEDICAL:			

Weight now:_____ Weight 6 months ago: _____

Any psychiatric illness? ❒ Yes ❒ No Any visual problems? ❒ Yes ❒ No

Any hearing problems? ❒ Yes ❒ No Any muscular or skeletal disorders? ❒ Yes ❒ No

Any fever, chills, night sweats? ❒ Yes ❒ No

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.