AMY GARCIA, MD
GYNECOLOGY

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____/_____/_____

Please explain what concerns brought you here today. _____

Gynecologic History

I. Menstrual Cycle

What was the first day of your last menstrual period?	
Have you gone through menopause?	Yes No
If yes, at what age?	Age
How many days does your period last?	days
How often do you get your period?	Every days
How would you describe the flow of your period?	Light Normal Heavy
Do you have cramping or pain with your period?	Yes No
If yes, how would you rate your pain with 10 being the worst?	1 2 3 4 5 6 7 8 9 10
Do you have pelvic pain **NOT** associated with your cycle or with vaginal sex?	Yes No
If yes, how would you rate your pain with 10 being the worst?	1 2 3 4 5 6 7 8 9 10

II. Childbirth and Sexual Activity

Have you ever been pregnant?	Yes No
Number of pregnancies	
Number of miscarriages	
Number of pregnancy terminations	
Have you ever given birth to a child?	Yes No
Number of vaginal births	
Number of cesarean sections	
Are you sexually active?	Yes No
Do you have pain with vaginal sexual activity?	Yes No
If yes, how would you rate your pain with 10 being the worst?	1 2 3 4 5 6 7 8 9 10
If you have ever had a sexually transmitted infection indicate which one/ones: NONE (HPV, HIV, herpes, chlamydia, gonorrhea, genital warts,)	Other:
What form of contraception are you using **NOW**, please indicate which one/ones: NONE (Pill, IUD, Implant, Vaginal Ring, Patch, Injection, Tubal ligation, Essure, Partner Vasectomy, Condom, Diaphragm)	Other:

III. Bladder and Bowel Health

Do you have problems with urinary incontinence (inability to control urination)?	Yes No
Do you have problems with stool incontinence (inability to control bowel movements)?	Yes No

The above information was reviewed with the patient.

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IV. Breast Health

Have you ever had a mammogram?	Yes No
If yes, when was your last exam?	Date:
Have you ever had an abnormal mammogram?	Yes No
If yes, what was the date, result and treatment?	

V. Cervical, Uterine and Ovarian Health

When was your last Pap smear?	Date:
Have you ever had an abnormal Pap smear?	Yes No
If yes, what was the date, result and treatment?	
Have you ever had a pelvic ultrasound?	Yes No
If yes, what was the date, result and treatment?	
Have you ever had an endometrial biopsy? (sampling of the uterine lining)	Yes No
If yes, what was the date, result and treatment?	
Please explain if you have any issues regarding your ovaries.	

VI. Surgical & Hospitalization History

Type of surgery or reason for hospitalization	Date of surgery or hospitalization	If you had complications, please explain

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VII Your Medical and Family History
Place a check for any past or present medical issues for yourself or your close blood relatives.
Y= You, M = Mother, F = Father, S = Sister, B = Brother, O= Other

Medical Problem: Please Circle Subcategory	Y	M	F	S	B	O	Please Explain
Anemia							
Asthma/lung disease							
Autoimmune disorder (Crohn's, lupus, RA, etc.)							
Arthritis							
Bleeding disorder							
Cancer (breast, colon, ovarian, uterine, cervix, other)							
Blood clotting disorder (blood clots in legs/lungs)							
Diabetes							
Elevated cholesterol							
Fibromyalgia/chronic pain							
Depression/anxiety/eating disorder/psychiatric illness							
Gastrointestinal disease (gallbladder, bowel, stomach, etc.)							
Heart disease							
Kidney disease (stone, bladder/kidney infections, etc.)							
Hypertension (high blood pressure)							
Liver disease/hepatitis							
Neurologic disease (seizure, migraine, stroke, etc.)							
Osteoporosis							
Skin disorder							
Thyroid or other glandular disorder							
Other:							

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Medication Allergies and Adverse Drug Reactions

I am allergic to: ☐ No Known Allergies ☐ Latex ☐ Shellfish ☐ Iodine **List medication allergies and adverse reactions below:**

_____

_____

Current Medications
Please list your medications, including birth control, vitamins, herbs and supplements.

Medication	Dose	Frequency	Medication	Dose	Frequency

Do you exercise regularly? ☐ Yes ☐ No

How often do you exercise? _____Minutes _____ x per week

What activities do you perform? _____

Smoking status:
☐ Non-smoker
☐ Current smoker How much do you smoke? _____ Packs / Day
☐ Check here if you would like information about quitting smoking.
☐ Smoked in the past? _____Packs / Day

Do you drink alcohol? ☐ Yes ☐ No # of drinks/week _____

Do you use recreational drugs? ☐ Yes ☐ No Please list: _____

Domestic Violence:

Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No

Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

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REVIEW OF SYSTEMS

Mark any symptoms you are experiencing TODAY.

Eyes		Ears		Nose		Head	
Recent changes in vision		Loss of hearing		Frequent Nosebleeds		Frequent headaches mild, moderate, severe	
Temporary vision loss		Ringing in ears		Hay fever			
Double/blurred vision		Ear discharge		Sinusitis		Light-headedness	
		Ear pain		Discharge from nose		Dizziness	
						Loss of consciousness	

Neurological		Respiratory		Neck/Throat		Heart	
Loss of sensation in limbs		Persistent cough		Persistent hoarseness		Irregular heartbeat	
Weakness in limbs/body		Cough with phlegm		Difficulty swallowing		Ankles/Feet swelling	
Seizures		Coughing up blood		Large thyroid/goiter		Shortness of breath while walking	
		Shortness of breath		Pain in neck/throat		Shortness of breath at night	
		Difficulty breathing		Change in voice quality		Palpitations	
						Chest pain	
						Chest tightness	

Digestive		Genitourinary		Musculoskeletal		Skin	
Gallbladder stones/pain		Kidney stones		Joint pain		Persistent itching	
Jaundice		Blood in urine		Muscle pain		Persistent skin pain	
Diverticulitis/colitis/enteritis		Urine/kidney infection		Muscle weakness		Recent change in skin	
Vomiting blood		Urinary leakage		Back pain		Recent change in hair	
Recent appetite change		Urinary urgency					
Change in bowels		Abnormal Uterine Bleeding					
Tar black/tar like stool		Heavy Regular Menstrual Bleeding					
Red blood in stool		Postmenopausal Bleeding					
Cramps/abdominal pain		Pelvic Pain					
Leakage of stool							
Hemorrhoids							
Constipation							

Misc.	
Bleeding from dental treatments	
Increased/Excessive thirst	
Frequently too hot or too cold	
Fatigue	

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