# Personal Medical Information

**Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

**Who are you here to see?** John Dulemba, MD, Suhas Mantri, MD, Amy Dean,WHNP-BC, Sara Muskopf, RDMS

**Race:** Caucasian/Non-Hispanic Caucasian/Hispanic African American Native American Asian Pacific Islander

**List any ALLERGIES you may have:** _____

**Check if YOU have had the following:**

- ☐ Breast Cysts / Tumors / Discharge
- ☐ Ovarian Cyst / Uterine Tumors
- ☐ Pelvic Infections (Uterus, Tubes, Ovaries)
- ☐ Chronic Pelvic Pain
- ☐ Chronic Vaginal Infections
- ☐ Endometriosis
- ☐ Dyspareunia (Painful Intercourse)
- ☐ Bleeding After Intercourse
- ☐ Abnormal Pap Smear Date: _____
  How was it treated? _____
- ☐ STD (Herpes, Gonorrhea, Syphillis, Trichomonas Chlamydia, Genital Warts, HPV Virus)
- ☐ HIV+ / AIDS
- ☐ Chronic Bladder Infections
- ☐ Urinary Incontinence (leaking)
- ☐ Interstitial Cystitis
- ☐ Osteopenia / Osteoporosis
- ☐ Stroke/Blood Clot/Blood Clotting Disorder
- ☐ Heart Attack
- ☐ Heart Problems (Murmurs)/Arrythmia
- ☐ High Cholesterol
- ☐ Lung Problem (short of breath, asthma, tuberculosis)
- ☐ High Blood Pressure
- ☐ Gall Bladder Problems/Stones
- ☐ Kidney Disease
- ☐ Cancer Type: _____
- ☐ Headaches/Migraine Headaches
- ☐ Depression / Anxiety
- ☐ Psychiatric Conditions/Mental Disability
- ☐ ADD / ADHD
- ☐ Diabetes / Type I / Type II
- ☐ Epilepsy / Seizures
- ☐ Thyroid Problems / Hypo / Hyper
- ☐ Varicose / Inflamed Veins
- ☐ Sickle Cell Disease /Trait
- ☐ Anemia
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Gastrointestinal Problems (Colitis, Crohn's, Chronic Constipation, Chronic Diarrhea)
- ☐ Hepatitis
- ☐ Rheumatoid Arthritis / Osteo Arthritis

**Are you being treated for anything or have you ever been treated for anything not listed? If so, what?** _____

_____

**Do you use recreational drugs?** Yes / No If yes, what type? _____

**Are you concerned about wrinkles or spider veins?** Yes / No

## Family Medical History

**Please check all that apply to your mother, father, sister(s), or brother(s):**

- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ History of Other Cancer Type: _____
- ☐ Diabetes / Type I / Type II
- ☐ Sickle Cell Disease / Trait
- ☐ Elevated Cholesterol
- ☐ Genetically Inherited Abnormalities: _____
- ☐ Other: _____

## Menstrual History

**Have you gone through menopause?** Yes / No If yes, what age? ____

**Have you had a hysterectomy?** Yes / No If yes, what was the reason? _____ Abdominal / Vaginal

**(If you answered yes to the above, then skip down to Reproductive history)**

**Age periods began:** ____ **First day of last NORMAL period:** _____

**Pain/Cramping with periods?** Yes / No If yes: Severe / Moderate / Mild

**Period every** ____ **days** **Period lasts** ____ **days** **Number of pads/tampons used per day:** ____

**Bleeding between periods?** Yes / No

## Contraceptive History

**Are you interested in a Birth Control Method at this time?** Yes / No

**Have you had unprotected intercourse since your last period?** Yes / No

**Please check which birth control methods you have used:**

- ☐ Abstinence
- ☐ Virgin
- ☐ IUD Kind: _____
- ☐ Nexplanon/Implanon
- ☐ Condoms
- ☐ Birth Control Pills Kind: _____
- ☐ Fertility Awareness
- ☐ Sterilization You / Partner
- ☐ Withdrawal
- ☐ Nuva Ring
- ☐ Ortho Evra Patch
- ☐ Same Sex Relationship
- ☐ Other: _____
- ☐ None

**Current Method:** _____ **How long have you used this method?** _____ **Problems?** _____

**Do you wish to continue this method?** Yes / No

## Reproductive History

**Total number of pregnancies including any miscarriages & abortions:** _____

**Number of full term babies:** ____ **Number of abortions:** ____ **Number currently living:** ____

**Number of miscarriages:** ____ **Number of premature babies:** ____

| Pregnancy | Vag, C/S, AB Miscarriage | Delivery Date | Complications |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

## Surgical History

**List date, surgeries (even as a child):** _____

_____

## General Information

**Usual Weight:** _____ **Height:** _____

**Date of last pap smear:** _____ Normal / Abnormal **Date of last mammogram:** _____ Normal / Abnormal

**List all medications you are currently taking:** _____

_____

**Do you use alcohol?** Yes / No If yes, amount per day/week: _____ **Do you smoke?** Yes / No If yes, amount per day: _____

**Do you use caffeine?** Yes / No If yes, amount per day: _____

**Who referred you to our office?** _____ **For what problem / reason are you here today?** _____