GORDON C. GUNN, M.D.
GYNECOLOGY • UROLOGY • WOMEN'S WELLNESS
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PATIENT MEDICAL HISTORY - FEMALE

Legal Name: _____ **Age:** _____ **Appointment Date:** _____

Marital Status: ☐ *Single* ☐*Married* ☐*Divorced* ☐*Widow* **Name of Primary Care Physician:** _____

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: _____

_____

_____

Menstrual History:

- Are you having regular menstrual periods? ☐Y ☐N If no, how frequent: _____
- Date of your last menstrual period: _____
- Has there been any recent change in your periods? ☐N ☐Y If yes, describe: _____
- Do you have pain with your periods? ☐N ☐Y If yes, severity (scale 1-10): _____

Pelvic symptoms: Do you have any of the following?

- Pelvic pressure, low back pain, sensation of your organs falling out? ☐N ☐Y
- Do you have episodes of pelvic pain? ☐N ☐Y If yes, severity (scale 1-10): _____
- PMS (i.e. irritability, weight gain, anxiety, bloating, or depression)? ☐N ☐Y
- Questions regarding your sexual response? ☐N ☐Y
- Number of lifetime sexual partners? _____

Menopause:

- Do you experience menopausal symptoms (hot flashes, night sweats)? ☐N ☐Y If yes, how often? _____

Current Method of Contraception (including vasectomy)**:** _____

Date of Last Pap Smear: _____ **History of abnormal Pap?** ☐N ☐Y If yes, when? _____

REVIEW OF SYMPTOMS

Are you currently experiencing any of the following symptoms? If YES, Please Describe:

- **General:** headaches, sleep problems, unusual fatigue? ☐N ☐Y _____
- **Eyes:** double vision, glaucoma, dryness? ☐N ☐Y _____
- **Ears, Nose, or Throat:** sinus problems, difficulty swallowing? ☐N ☐Y _____
- **Cardiovascular:** chest discomfort, unusual heart beat, mitral valve prolapse, high blood pressure, leg swelling, shortness of breath, dizzy spells? ☐N ☐Y _____
- **Respiration:** asthma, chronic cough? ☐N ☐Y _____
- **Breasts:** cysts, nodules, pain? ☐N ☐Y _____
- **Skin:** acne, moles, cancer? ☐N ☐Y _____
- **Gastro-Intestinal:** abdominal pain, bloating, diarrhea, constipation, IBS symptoms, liver disease, rectal bleeding, stool leakage? ☐N ☐Y _____
- **Urinary:**
  - Recent kidney or bladder infection? ☐N ☐Y
  - Loss of urine when coughing, sneezing, or exercising? ☐N ☐Y
  - Able to go for more than 3 hours without urination? ☐N ☐Y **If No**, How frequent? Every _____ Hrs
  - Wear a pad for "just in case" protection? ☐N ☐Y
  - Regularly get up at night to urinate? ☐N ☐Y **If Yes**, Number of times _____
  - Avoid physical activities due to poor bladder control? ☐N ☐Y
- **Endocrine:** excessive thirst, fatigue, too hot/cold? ☐N ☐Y _____
- **Hematologic/Lymphatic:** anemia, swollen glands? ☐N ☐Y _____
- **Musculo-Skeletal:** neck, back or joint pain, muscle pain? ☐N ☐Y _____
- **Neurologic:** numbness, seizures, history of stroke or TIA? ☐N ☐Y _____

PERSONAL, FAMILY AND SOCIAL HISTORY

Personal History:

- **Obstetrical History:**
  # of Pregnancies: _____ # of Vaginal Deliveries: _____ # of C-Sections: _____ # of Miscarriages: _____
- **Serious Illnesses, Injuries, Hospitalizations:** (Please list}

  _____ _____

  _____ _____
- **Major Operations:** (Please List & Indicate Year of Surgery)

  _____ _____

  _____ _____
- **Family History:** Do <u>any</u> of your family members have a history of: Heart Disease; Stroke; Sudden Death; Diabetes; Cancer; Endometriosis; Osteoporosis, Alzheimer's or Dementia? **If yes**, please **<u>List</u>** and note age.
  - Father: _____
  - Mother: _____
  - Brother(s): _____
  - Sister(s): _____
  - Maternal Aunt(s): _____
  - Maternal Grandmother: _____
  - Maternal Grandfather: _____
- **Social History:**
  - Do you smoke? ☐N ☐Y If yes, number of packs/day? _____ How many years? _____
  - Do you drink alcohol? ☐N ☐Y If yes, more than 2 drinks/day? ☐N ☐Y If yes, amount? _____
  - Do you exercise regularly? ☐N ☐Y If yes, describe: _____
  - What is your occupation? _____
  - What are your hobbies? _____
  - What is your stress level? ☐ None ☐ Low ☐ Moderate ☐ High

HEALTH SCREENING STUDIES

Have you had <u>any</u> of the following tests? If <u>yes</u>, please indicate most recent year

			YEAR
♦ Mammogram	☐N	☐Y	_____
♦ Bone Density (DXA Scan) for Osteoporosis	☐N	☐Y	_____
♦ Colonoscopy	☐N	☐Y	_____
♦ Immunizations:			
• Gardasil (HPV) (Age 9-26)	☐N	☐Y	_____
• Hepatitis A/B	☐N	☐Y	_____
• Tetanus (within last 10 years?)	☐N	☐Y	_____
• Shingles (Age 60 or over)	☐N	☐Y	_____
• Pneumonia (Age 65 or over)	☐N	☐Y	_____
♦ Cardio-Vascular Testing:			
• EKG (Electrocardiogram)	☐N	☐Y	_____
• Carotid Artery Ultrasound (Stroke Risk)	☐N	☐Y	_____
• Echo Cardiogram of Heart	☐N	☐Y	_____
• Stress Test	☐N	☐Y	_____
♦ Hereditary Cancer Screening:	☐N	☐Y	_____ Result? _____
♦ Has <u>anyone</u> in your family had a Hereditary Cancer?	☐N	☐Y	

- **If yes**, then please **<u>indicate family relationship</u>**, **<u>type of cancer</u>** and **<u>age when diagnosed</u>**
- _____ • _____

Pharmacy Information: TO FAX YOUR PRESCRIPTIONS, Please provide the following information:

Pharmacy: _____ **Address:** _____

Phone #: **Fax #:**

I invite you to explore my Website!

www.GordonGunnMD.com Provider's Signature: _____ Date: _____ Revised: 4.24.2017