



GORDON C GUNN, MD, FACOG

CONCIERGE PERSONALIZED CARE
GYNECOLOGY • HORMONE THERAPY
INTEGRATIVE MEDICINE

PATIENT MEDICAL HISTORY - FEMALE

Legal Name: _____ DOB: _____ Date: _____ Marital Status: M S D W

Name of Primary Care Physician: _____

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: _____

Menstrual History:

- Are you having regular menstrual periods?
Date of your last menstrual period:
Has there been any recent change in your periods?
Do you have pain with your periods?

Pelvic symptoms: Do you have any of the following?

- Pelvic pressure, low back pain, sensation of your organs falling out?
Do you have episodes of pelvic pain?
PMS (i.e. irritability, weight gain, anxiety, bloating, or depression)?
Questions regarding your sexual response?
Number of lifetime sexual partners?

Menopause:

- Do you have menopausal symptoms (hot flashes, night sweats)?

Current Method of Contraception (including vasectomy): _____

Date of Last Pap Smear: _____ History of abnormal Pap? _____

REVIEW OF SYMPTOMS

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

- General: headaches, sleep problems, unusual fatigue?
Eyes: double vision, glaucoma, dryness?
Ears, Nose, or Throat: sinus problems, difficulty swallowing?
Cardiovascular: chest discomfort, unusual heart beat, mitral valve prolapse, high blood pressure, leg swelling, shortness of breath, dizzy spells?
Respiration: asthma, chronic cough, difficulty breathing?
Breasts: cysts, nodules, pain?
Skin: acne, moles, cancer?
Gastro-Intestinal: abdominal pain, bloating, diarrhea, constipation, IBS symptoms, liver disease, rectal bleeding, stool leakage?
Urinary: Recent kidney or bladder infection? Loss of urine when coughing, sneezing, or exercising? Able to go for more than 3 hours without urination? Wear a pad for "just in case" protection? Regularly get up at night to urinate? Avoid physical activities due to poor bladder control?
Endocrine: excessive thirst, fatigue, too hot/cold?
Hematologic/Lymphatic: anemia, swollen glands?
Musculo-Skeletal: neck, back or joint pain, muscle pain?
Neurologic: numbness, seizures, history of stroke or TIA?

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 each surgery)

◆ **Family History:** Do **any** of your family members have a history of: Heart Disease; Stroke; Sudden Death; Diabetes; Cancer; Endometriosis; Osteoporosis, Alzheimer's or Dementia? **If yes**, please **List** 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 any of the following tests? If yes, 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? _____

PHARMACY: To FAX of E-Scribe your prescriptions, Please provide the following:

Pharmacy: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

I invite you to explore my Website: www.GordonGunnMD.com

Provider's Signature: _____ Date: _____ Revised: 01.08.2018