MADIGAN ARMY MEDICAL CENTER

Department of OB/GYN Gynecologic History Form

Name:_____ Date:_____
Date of Birth:_____ Pronouns: _____
Phone number where a detailed message with personal health information can be left:_____

MHS Genesis patient portal is the standard method for results. □ I can use the Portal □ I CANNOT access the Portal
Where is your preferred pharmacy? □ Madigan Pharmacy □ Other (name & location) _____
Do you have paperwork that needs to be filled out today? □YES □NO

What are the two most important problems we can address for you today?

_____
_____
What would make you completely satisfied with the healthcare you receive at this visit? _____
_____

How long has this problem been going on? _____ DAYS WEEKS YEARS

How is the problem you are currently having affecting your life?

_____
_____

What have you already tried for this problem? (ie medication, surgeries, other physicians, alternative therapies):

_____

Are you in pain today? □YES □NO If yes, where is your pain? Can you describe it? (ie sharp, dull, cramping)

_____

What was the first day of your last menstrual period? _____ Sure / Unsure
Are you currently trying to become pregnant? □YES □NO

What are you using for birth control right now (circle)?

Pills	Patches	Vaginal Ring	Depo Provera Shot	Nothing
Vasectomy	Condoms	Tubes tied	Diaphragm/Cervical cap	Nexplanon
No sex in last 3 months		IUD	Natural Family Planning/Lactation	Same sex relationship

Medical History (do <u>you</u> currently or have you ever had):

□ Genetic disease	□ Cancer	□ Major trauma/injury/broken bone
□ Thyroid disease	□ Liver problems	□ Behavioral health issue (ie.depression, anxiety, PTSD)
□ Diabetes or prediabetes	□ High blood pressure	□ Easy bleeding (ie at surgery/dental work, nose bleeds)
□ Heart problems	□ Blood transfusion	□ Lung problems (ie asthma)
□ Kidney problems	□ Anemia/low iron	□ Blood clots (ie PE/DVT)
□ Seizures	□ Migraine headaches	□ Autoimmune disorder (ie antiphospholipid syndrome)
□ Lipid/Cholesterol problems	□ Obesity	□ Heart attack or stroke
		□ Stomach/Intestine problems (ie IBS, GERD, IBD)

Other (list all other medical problems):

_____
_____

Do you have <u>family history</u> of the following (in your grandparents, parents, children, siblings or aunts/uncles)?

□ High blood pressure	□ Diabetes	□ Easy bleeding	□ Blood clots (ie DVT or PE)	□ Osteoporosis
□ Heart attack/heart disease	□ Stroke	□ Endometriosis	□ Anesthesia issues	□ Fibroids
□ Birth defects (ie spinabifida, club foot, cleft palate, heart defect)			□ Mental health issues	

□ Genetic diseases (ie downs syndrome, cystic fibrosis, sickle cell, hemophilia, mental retardation, muscular dystrophy)
□ Cancer of the breast, colon, ovary or uterus □ Other cancers: (list)_____

Allergies (please list with reaction):

Have you ever had surgery? (Please write year next to procedure) □YES □NO

□ Organ transplant	□ Cesarean section	□ Cervical surgery (ie LEEP or Cone)	□ Breast surgery
□ Laparoscopy	□ Tubal surgery	□ Bariatric/weight loss surgery	□ Tonsils or Adenoids
□ Appendix surgery	□ Tubes tied/sterilization	□ Hysterectomy (uterus removed)	□ Eye surgery (ie Lasix)
□ Gallbladder surgery	□ Ectopic pregnancy surgery	□ Uterine surgery	□ Orthopedic surgery
□ Bowel surgery	□ Ovarian surgery	□ D&C	□ Dental (ie wisdom)

Other (list all other surgical procedures):_____
_____

Medications (please include all prescriptions, over the counter medications, prescription medications that weren't prescribed to you, hormonal therapies, herbs, vitamins or alternative therapies):

Gynecologic History:

How old were you when your periods started?_____ Have they stopped? □YES □NO (if yes, when _____)
How many days between the start of one period to the start of the next?_____
How many days of bleeding do you have during your period?_____

Have you ever had:

□ Abnormal pap smear/HPV	□ Endometriosis	□ PCOS
□ Infertility	□ Fibroids	□ Ovarian cysts
□ Chlamydia or gonorrhea	□ Syphilis	□ Pelvic Inflammatory Disease (PID)
□ Herpes (HSV)	□ Trichomonas	□ Genital warts/HPV
□ Abnormal uterus (septate/bicornuate)	□ HIV/AIDS	□ Completed your Gardasil/HPV vaccine series

Do you currently have:

□ Unintentional leakage of urine	□ Unintentional leakage of stool	□ Feeling a bulge in the vagina
□ Bleeding between periods	□ Spotting before period starts	□ Bleeding after menopause
□ Heavy periods	□ Painful periods	□ Skin changes on your vulva or vagina
□ Hot flashes	□ Vaginal dryness	□ Abnormal vaginal discharge
□ Pain with sex	□ Pelvic pain	□ Soiling of clothing/bedding with period

Personal and Sexual History:

Are your partners (circle): MEN WOMEN BOTH OTHER NONE
How many sexual partners have you had in the last 12 months? _____ □ Prefer not to answer
Are you having any issues with sex? □YES □NO If so, what? _____
Have you ever been a victim of sexual abuse or sexual violence? □YES □NO
Do you currently use any drugs (including marijuana)? □YES □NO
Do you currently use tobacco or vape? □YES □NO If yes, how much/how often?_____
Do you currently drink alcohol? □YES □NO If yes, how much/how often?_____
Do you currently feel safe at home? □YES □NO
Do you have guns in your home? □YES □NO
Do you wear your seatbelt regularly? □YES □NO
What do you currently do for exercise? _____How often?_____
What do you do for work?_____
Describe your diet/nutrition: _____
On a scale of 0-10, (10 being the healthiest) how healthy is your lifestyle?_____
What is your current relationship status: MARRIED SINGLE WIDOW LONG TERM RELATIONSHIP(S)

Pregnancy history:

Number	Date (mo/yr)	Pregnancy outcome: Cesarean, vaginal, forceps, vacuum miscarriage, abortion, ectopic pregnancy	Weeks pregnant at end of pregnancy	Complications (diabetes, high blood pressure, hemorrhage, growth restriction, stillbirth)	Weight of baby
1				YES / NO	
2				YES / NO	
3				YES / NO	
4				YES / NO	
5				YES / NO	
6				YES / NO	

Preventative Health:

Would you like to be screened for sexually transmitted infections today?	□YES	□NO	
Do you want to become pregnant at some point in the future?	□YES	□NO	
Would you like to change your current form of birth control?	□YES	□NO	
Have you had an HIV test as an adult?	□YES	□NO	□ N/A
Have you been tested for hepatitis C once as an adult? (if born 1945-1965)	□YES	□NO	□ N/A
If over 40, have you had a mammogram this year?	□YES	□NO	□ N/A
If over 45, have you had a colonoscopy?	□YES	□NO	□ N/A
If over 65, have you had a dexa scan?	□YES	□NO	□ N/A

When was your last cholesterol test? _____□ N/A When was your last diabetes test? _____□ N/A

Have you experienced any of the following <u>in the last month</u>? (check box for YES)

Constitutional:	□unexplained weight change □night sweats □fatigue □ appetite changes
Cardiovascular:	□chest pain □exercise intolerance □heart palpitations □fainting
Respiratory:	□cough □shortness of breath □wheezing
Gastrointestinal:	□abdominal pain □indigestion/acid reflux □bloating/fullness □cramping □nausea □vomiting □diarrhea □constipation □blood in stool
Genitourinary:	□ pain with urination □blood in urine □urinating frequently
Musculoskeletal:	□joint pain □stiffness □swelling □decreased range of motion
Skin/Breast:	□itching □rashes □breast pain □breast lumps □nipple discharge □breastfeeding
Neurological:	□tingling □numbness □limb weakness □poor balance □seizures □headaches
Psychiatric:	□depression □sleep problems □anxiety □difficulty concentrating □mood swings □relationship issues
Endocrine:	□Intolerance of hot or cold weather □dizziness □sweating
Hematologic/lymphatic:	□anemia □easy bleeding □ easy bruising □ nose bleeds

Do you have a living will or advanced directive? □YES □NO
If you were unable to make healthcare decisions for yourself, who would make those?_____(relationship to you)
Name:_____ Phone number:_____
If your heart stopped beating and/or you stopped breathing, would you want all resuscitation procedures to be provided to keep you alive? This is CPR and can include chest compressions, intubation and defibrillation. □YES □NO

What information can we provide you to help you improve your health today?

□ Healthy eating/nutrition	□ Weight loss	□ Relationship help	□ Mental health/behavioral health
□ Exercise	□ Sexual health	□ Breast health	□ Heart health
□ Vaccines I should get	□ Bone health	□ Safer sex practices	□ Advanced directives/Living will
□ Planning a healthy and/or future pregnancy		□ Quitting tobacco	□ Addiction (drugs, alcohol)

Please read the information provided regarding speculum, breast and pelvic exams. You and your provider will review your history and if there are indications for an exam. So that we can better understand, what are your preferences?

Speculum exam	□Want exam	□Prefer to avoid exam unless necessary
Pelvic exam	□Want exam	□Prefer to avoid exam unless necessary
Clinical breast exam	□Want exam	□Prefer to avoid exam unless necessary

To the best of my knowledge I have completed this form accurately. I understand that providing incomplete or inaccurate information can be dangerous to my health.

Signature:

_____Date:_____

GYN Nursing Form

Vital Signs:
BP:_____ P:_____ RR:_____ T:_____ Ht:_____ Wt:_____

LMP:_____ Room:_____

Allergies:

1._____ **Smoke:** ☐ YES ☐ NO

2._____ **ETOH:** ☐ YES ☐ NO

3._____ **PAIN:** ☐ YES ☐ NO (__/10)

4._____ G___T___P___A___LC___

Gardasil: ☐ Received ☐ Not Received
☐ > 26 years old

REMEMBER TO PERFORM MEDICATION RECONCILIATION!