40636

MR-167 (1-2017)

**WOMEN & INFANTS HOSPITAL**
Providence, RI 02905

**UROGYNECOLOGY HEALTH HISTORY**

**FOR INPATIENTS:** AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

**FOR OUTPATIENTS:** WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

**Name:** _____ **Date of birth:** _____

**What is the reason for your visit today**? _____

**Past Medical History**: Do you have any of the following problems now or in the past?

☐ Glaucoma
☐ Tuberculosis
☐ Heart attack
☐ Endocarditis
☐ Hyperlipidemia
☐ Blood clotting disorder
☐ Anemia
☐ Diverticulosis
☐ GI bleeding
☐ Crohn's disease
☐ Rectal bleeding
☐ Diabetes type 1
☐ Osteoporosis
☐ Ovarian cyst
☐ Interstitial cystitis
☐ Polycystic kidney
☐ Dementia
☐ Spinal stenosis
☐ HIV/AIDS
☐ Insomnia
☐ Asthma
☐ Sleep apnea
☐ Heart disease
☐ Heart murmur
☐ Blood clot in lung
☐ Rheumatic fever
☐ Chronic pelvic pain
☐ Diverticulitis
☐ Hepatitis (type_____)
☐ Irritable bowel syndrome
☐ Stomach ulcer
☐ Diabetes type 2
☐ Endometriosis
☐ Frequent UTIs
☐ Kidney disease
☐ Urine leakage
☐ Seizures
☐ Fibromyalgia
☐ Cancer (type_____)
☐ Anxiety
☐ COPD
☐ Irregular heart rhythm
☐ Heart failure
☐ High blood pressure
☐ Blood clot in leg
☐ Stroke
☐ Chronic diarrhea
☐ Acid reflux
☐ Ulcerative colitis
☐ Jaundice
☐ Diabetes insipidus
☐ Thyroid (hypo or hyper)
☐ Fibroids
☐ Blood in urine
☐ Kidney stones
☐ Multiple sclerosis
☐ Arthritis
☐ Depression
☐ Bipolar disorder
☐ Other:_____

**Past Surgical History**

☐ Cataract surgery
☐ Mastectomy
☐ Heart bypass surgery
☐ Appendix removed
☐ Knee replacement
☐ Laparoscopy
☐ C-section
☐ Vaginal prolapse surgery
☐ Bladder cancer surgery
☐ Spine surgery
☐ Tonsils removed
☐ Carpal tunnel surgery
☐ Gallbladder surgery
☐ Hernia repair
☐ Colon surgery
☐ D&C
☐ Ovaries removed
☐ Anal sphincter surgery
☐ Bladder lift surgery
☐ Breast surgery
☐ Heart valve surgery
☐ Gastric bypass (for weight loss)
☐ Hip replacement
☐ Kidney stone removal
☐ Hysterectomy
☐ Tubes tied
☐ Bladder sling (for leakage)
☐ Skin cancer removal

Other:

_____

_____

**List of medications:** Please list all of the medications you take (including non-prescription, vitamins, herbs)

_____

_____

_____

**Are you allergic to any medications?**

_____

**OVER**

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# UROGYNECOLOGY HEALTH HISTORY

FOR INPATIENTS: AFFIX PATIENT LABEL OR WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

Name: _____ Date of Birth: _____

**Review of Systems:** Do you have any of the following problems now?

| |
|---|
| **Constitution:** ☐ Feeling tired ☐ Fever ☐ Unexpected weight loss ☐ Unexpected weight gain |
| **HEENT**: ☐ Dental problem ☐ Hearing loss ☐ Mouth sores ☐ Nosebleeds ☐ Trouble swallowing |
| **Eyes**: ☐ Eye pain |
| **Respiratory**: ☐ Chest tightness ☐ Cough ☐ Shortness of breath ☐ Wheezing |
| **Cardiovascular**: ☐ Chest pain ☐ Leg swelling ☐ Palpitations |
| **Endocrine:** ☐ Cold intolerance ☐Extreme thirst |
| **GI:** ☐ Abdominal pain ☐ Anal bleeding ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Rectal pain ☐ Vomiting |
| **GU:** ☐ Difficulty urinating ☐ Pain with sex ☐ Leaking urine while sleeping ☐ Urinating frequently ☐ Blood in urine ☐ Pelvic pain ☐ Vaginal bleeding ☐ Vaginal discharge |
| Allergy/Immune system: ☐ Environmental allergies ☐ Food allergies ☐ Weakened immune system |
| **Neuro**: ☐ Dizziness ☐ Headaches ☐ Passing out ☐ Weakness |
| **Hematologic**: ☐ Swollen lymph nodes ☐ Bruise or bleed easily |
| **Psychiatric**: ☐ Confusion ☐ Trouble sleeping ☐ Thoughts of suicide |

**Gynecologic History**

Last menstrual period:_____(approximate date)

If you are postmenopausal, have you had any bleeding since your last period?_____

Are you sexually active?_____Do you have any pain with sex?_____

How do you prevent pregnancy? _____ ☐ Not applicable

Have you ever had any sexually transmitted infections? ☐ Yes ☐ No

If yes, please check: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Genital warts ☐ Syphilis ☐ Trichomonas

Date of last Pap smear (if known):_____ Have you had abnormal Pap smears in the past?_____

**Obstetric History**

Please list the number of times you have had:

Pregnancy_____ Full term delivery_____Premature births_____Miscarriages_____Abortion_____Living Children _____

**Social History**

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many alcoholic drinks do you have each day?_____

Do you use tobacco? ☐ Never ☐ Quit (when)_____ Current packs/day_____

Do you use any illegal drugs (marijuana, cocaine, heroin, pain meds)? ☐ No ☐ Yes (type)_____

Is anyone close to you threatening or hurting you? ☐ No ☐ Yes

Is anyone hitting, kicking, choking, or hurting you physically? ☐ No ☐ Yes

Is anyone forcing you to do something sexually that you do not want to do? ☐ No ☐ Yes

**Family Medical History**

| | **Medical Problems** | **If Deceased, Cause of Death** |
|---|---|---|
| Father | | |
| Mother | | |
| Siblings | | |
| | | |
| Children | | |
| | | |
| | | |

Signature of Patient:_____ Date:_____