GYNECOLOGIC SPECIALISTS OF BREVARD, LLC

HEALTH HISTORY

Name: _____ Social Security #: _____ Appt. Date: _____
Address: _____ City / State / ZIP: _____
Date of Birth: _____ Age: _____ Partner / Spouse's Name: _____
Occupation: _____ Employer Name: _____
Daytime Phone: _____ Evening Phone: _____

1. **ALLERGIES:** Do you have allergies to any medications? No_____ OR If Yes, please list:
   Medicine _____ Reaction _____
   Medicine _____ Reaction _____
   Do you have any other allergies? No _____ If Yes, please list: _____
   _____

2. **MEDICATIONS**: Are you using any medications? No _____ If yes, please list:
   Medication _____ Dosage _____ Given by Dr._____
   Medication _____ Dosage _____ Given by Dr._____
   Medication _____ Dosage _____ Given by Dr._____
   Medication _____ Dosage _____ Given by Dr._____
   Medication _____ Dosage _____ Given by Dr._____

3. **GYNECOLOGICAL SURGERY HISTORY**: Have you had any operations including breast surgery, Tubal Ligation, Cervical Cone Biopsies, or other gynecological surgeries? No_____ If yes, please list:
   Year _____ Operation _____
   Year _____ Operation _____
   Year _____ Operation _____
   Year _____ Operation _____

4. **OTHER SURGICAL HISTORY**: Any other hospitalizations? No _____ If yes, please list:
   Year _____ Reason _____
   Year _____ Reason _____
   Year _____ Reason _____
   Year _____ Reason _____
   Year _____ Reason _____

5. **PREGNANCIES:** List your total # of pregnancies: _____
   # of Normal Deliveries _____ Dates & birth weight _____
   # of premature births _____ Dates & birth weight _____
   # of Cesarean Births _____ Dates & birth weight _____
   # of elective abortions _____ Dates _____
   # of Miscarriages _____ Dates _____

6. **CONTRACEPTION**: What are you using for contraception? _____

7. **PAP HISTORY**: Your last Pap (Cancer) Smear? Date _____ Result _____
   Have you ever had an Abnormal Pap Smear? _____
   If yes, give details of treatment with dates _____

8. **MENSTRUAL HISTORY**: First day of your last menstrual cycle? _____ Duration _____
   Cycle Length?(days between periods) _____ Do you have painful periods? _____
   I stopped having periods: (date) _____

9. **SOCIAL HISTORY:**
   Do you smoke? No _____ Yes _____ Packs per day? _____ Years? _____
   Do you drink? No _____ Yes _____ Drinks per day?_____ Drinks per week? _____
   Are you: Married? _____ Single?_____ Divorced? _____ Engaged? _____
   Do you use any form of recreational drugs? No ___Yes ___ Explain: _____

10. **HEALTH HISTORY:**

Have you or any of your family members had any of the following:

ILLNESS:	**YOU**	**FAMILY MEMBER (GF, GM, F, M, B, S)**
Arthritis / Joint Pain?		
Asthma?		
Blood Clots in legs or lungs?		
Cancer, Explain?		
Chronic Lung Disease?		
Depression?		
Diabetes?		
Drinking Problem?		
Drug Addiction?		
Glaucoma?		
Heart Disease?		
Hepatitis / Yellow Jaundice?		
High Blood Pressure?		
Kidney Disease?		
Osteoporosis?		
Phlebitis		
Pneumonia?		
Seizures / Convulsions / Epilepsy?		
Stroke?		
Thyroid Disease?		
Tuberculosis?		
Ulcers?		

13. **PERSONAL HISTORY**: Do you have any of the following: (check each applicable answer)

Abnormal Periods?	Anemia?
Painful Intercourse?	Bruise Easily?
Venereal Disease?	Abnormal Thirst?
Bloody Stool?	Enlarged Lymph Nodes?
Constipation?	Hot Flashes?
Diarrhea, frequent?	Recent Weight Loss / Gain?
Nausea / Vomiting?	Chest Pain?
Blood in Urine?	Heart Palpitations?
Pain with Urination?	Swelling of legs?
Urgency?	Abnormal Hair Growth?
Frequency of Urination?	Sinus Problems?

Do you loose urine when you cough or sneeze? _____

Do you have breast implants? _____ Date of your last mammogram? _____

Have you ever been on Hormone Replacement Therapy? _____

Have you ever had a Bone Density Scan? _____ If so, give last date: _____

Are there any other problems or concerns you would like to address with the physician today? No _____ OR

If yes, please list: _____

_____

_____

_____

_____.

This form completed by: _____ **Patient** _____ **Physician** _____ **Nurse**

Patient Signature _____ Date Signed _____

Physician Signature _____ Date Reviewed w/Patient _____

ANNUAL REVIEW OF HISTORY:

Physician Signature _____ Date Reviewed w/Patient _____

Physician Signature _____ Date Reviewed w/Patient _____

Physician Signature _____ Date Reviewed w/Patient _____

Physician Signature _____ Date Reviewed w/Patient _____