

CENTER FOR SPECIAL MINIMALLY INVASIVE SURGERY
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PATIENT HISTORY FORM

Today's Date _____

** Please complete this form as accurately as possible. Please print

Name: _____ Age: _____

Date of birth: ____/____/____ Marital Status: S M D W

Email address: _____

Address: _____ City: _____ ST:____ Zip: _____

Home phone: () _____ Wk () _____ Cell () _____

Social Security Number: _____ - _____ - _____

Person to notify in case of emergency: _____ Relationship: _____

Contact phone number: () _____

Primary Care Physician: _____ Phone () _____

Internal Medicine: _____ Phone () _____

CHIEF COMPLAINT

Reason for today's visit: _____

HISTORY OF PRESENT ILLNESS

Severity: mild/moderate/severe/other _____ (circle one)

Duration: < 6 months / > than 6 months / other _____

Timing: cyclic / acyclic / intermittent / other _____

Associated Symptoms: bladder / bowel / other _____

REVIEW OF SYSTEMS

GENERAL HEALTH

- Unexplained and sudden weight loss or gain
- Fever
- Fatigue
- Hot flashes/night sweats
- Shortness of breath
- Palpitations
- Chest pain
- Depression/Crying
- Anxiety
- Insomnia
- Other

URINARY HEALTH

- Painful urination
- Blood in urine
- Urgency (desire to use bathroom immediately)
- Frequency (desire to use bathroom too frequently)
- Incontinence If yes, do you notice it when you cough / sneeze / laugh **Y N**
- History of frequent urinary tract infections?
- How many times during the day do you go to the bathroom? 3-6 7-10 11-14 (more)
- How many times a night do you go to the bathroom? 0 1 2 3
If you get up at night, to what extent does it bother you?
 None Mild Moderate Severe
- Do you still have urgency after you urinate? **Y N**
- How often does your urgency bother you? Never Occasionally Usually Always

GYNECOLOGICAL HEALTH

Last menstrual period: ____/____/____

- * Do you spot between your periods? **Y N**
- * What age were you when you started menstruating? _____

Menstruation occurs every _____ days and lasts for _____ days.

- Regular
- Irregular
- On continuous birth control (acyclic – stops periods)
- Painful periods/heavy bleeding/clotting/unexplained absence of periods (Circle all that apply)

Last PAP smear ____/____/____ Results _____

- * Do you have history of abnormal pap? **Y N** Result/Treatment _____

Last Mammogram ____/____/____ Results _____

- * Do you have history of abnormal mammogram? **Y N** Results/Treatment _____
- * Do you perform your own self breast exams every month? **Y N**

Have you ever had an endometrial biopsy done? **Y N** If so, when/results _____

Patient Name _____

Have you ever had a colorectal screening? **Y N** If so, when/results _____

- Are you currently sexually active? **Y N**
 - How old were you at the time of FIRST intercourse _____
 - How many sexual partners do you currently have? _____
 - Are you able to have an orgasm? **Y N**
 - Are you able to become sexually aroused? **Y N**
 - If you are sexually active, do you have pain or urgency to urinate during or after intercourse? Never Occasionally Usually Always
 - Have you ever had :
 - Chlamydia When? _____
 - Herpes When? _____
 - Gonorrhea When? _____
 - Condyloma (warts) When? _____
 - Exposure to HIV? When? _____
 - Have you had the Gardasil Injection? **Y N**
 - Do you consider yourself to be heterosexual/bisexual/homosexual (circle all that apply)
 - Current birth control method _____
 - Have you ever been the victim of sexual abuse? **Y N**
-

GASTROINTESTINAL HEALTH

- Diarrhea
- Constipation
- Nausea and vomiting
- Painful bowel movements
- Irritable bowel syndrome

HEMATOLOGY/LYMPH SYSTEM

- Bruise easily
- Bleeding problems (i.e. cuts that take a long time to stop bleeding)
- Large lymph nodes

ALLERGIES

- None
- Drug _____ Reaction _____
- Drug _____ Reaction _____
- Drug _____ Reaction _____
- Do you suffer from seasonal allergies? **Y N** Worse during summer/fall/winter/spring

MEDICATIONS

- None
- Drug/dosage _____
- Drug/dosage _____
- Drug/dosage _____

Patient Name _____

PAST MEDICAL HISTORY Check all that apply past OR present

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis Type _____ |
| * Do you have mitral valve prolapse? Y N | <input type="checkbox"/> Phlebitis (blood clot) |
| If so, do you require antibiotics? Y N | <input type="checkbox"/> Pulmonary Embolus (clot in lungs) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Other _____ | |

SURGICAL HISTORY

Please list all in and out patient surgical procedures and their dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you ever had a problem with general anesthesia? **Y N** If yes, describe _____

Have you ever been hospitalized other than surgery? If yes, explain _____

SOCIAL HISTORY

Occupation _____

Do you smoke? **Y N** If yes, how many packs per day _____

Are you currently or have you ever used recreational drugs? **Y N**

If yes...Type _____ When did you stop? _____

Do you drink alcohol? **Y N** If yes, how many per week? _____

Have you ever been or are you currently a victim of domestic violence? **Y N**

Have you ever been sexually assaulted? If yes, when _____

- Was this reported to authorities? _____

FAMILY HISTORY List all serious illness and age of onset. State age and cause of death if applicable

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Patient Name _____

Has anyone in your family had breast cancer? **Y N** If yes, who? _____ Age? _____

History of other family cancer? **Y N** If yes, who and type _____

If you are African American have you been tested for sickle cell traits? **Y N**

* If yes, results _____

If you are Jewish have you been tested for Tay Sachs disease? **Y N**

* If yes, results _____

Do any women in your family suffer from osteoporosis/hip fractures? **Y N** If yes, who _____

Are there any inherited diseases in your family such as Hemophilia, MS, Cystic Fibrosis? **Y N**

* If yes, who _____

Are there any birth defects or open spine defects (spina bifida, aencephaly) **Y N**

* If yes, who _____

DIET

Regular

Special _____

Are you a vegetarian? **Y N** Do you consume dairy? **Y N** Fish? **Y N**

Do you use any herbal supplements at all? **Y N** If yes, type _____

Do you take calcium daily? **Y N** If yes, how much _____

Do you exercise regularly? **Y N** If yes, type _____

OBSTETRICAL HISTORY

None

Number of pregnancies _____ How many deliveries? _____

How many living children? _____ How many miscarriages? _____

How many abortions? _____ How many vaginal deliveries? _____ C-section? _____

FERTILITY HISTORY

Do you intend to get pregnant? **Y N** When do you plan to try? _____

How long have you and your partner been attempting pregnancy? _____

Have you been treated for infertility previously? **Y N**

If yes, where and when? _____

Which tests have been performed?

Basal body temperature

Infection test (ureaplasma, mycoplasma)

Estradiol

Post coital test

Endometrial biopsy

FSH

Clomid challenge test

Hysterosalpingogram

DHEAS

Sonohysterogram

Antibody tests

Thyroid

Testosterone

Ultrasound

Patient Name _____

Have you ever taken any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Clomid | <input type="checkbox"/> Letrazole | <input type="checkbox"/> HcG (Ovidrel) |
| <input type="checkbox"/> Injectable Gonadotropins | <input type="checkbox"/> Progesterones | <input type="checkbox"/> Progestins |
| <input type="checkbox"/> Estrogens | <input type="checkbox"/> Testosterone | |

Have you ever attempted intrauterine insemination? **Y N**

If yes, how many times: _____ Dates: _____

Was specimen provided by Donor Partner

Have you ever attempted in vitro fertilization? **Y N**

If yes, how many times? _____

Has your male partner had any of the following tests done?

- | | | |
|--|--|---|
| <input type="checkbox"/> Semen analysis | <input type="checkbox"/> Chromosome test | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Testicular biopsy | <input type="checkbox"/> Hormonal test | <input type="checkbox"/> Xray of testes |

Has your male partner ever had surgery involving the reproductive tract?

- | | | |
|--|--|--|
| <input type="checkbox"/> Varicocele repair | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Vasectomy reversal |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Repair of obstruction of vas deferens | |
| <input type="checkbox"/> Prostate surgery | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Testicular torsion repair |

Has your male partner ever had significant testicular injury? **Y N**

If yes, explain _____

Patient history reviewed by Dr. _____

Physician signature: _____

Date: _____