

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 _____

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 _____

PAST MEDICAL HISTORY Check all that apply past OR present

- | | |
|---|---------------------------------------|
| () High blood pressure | () Pneumonia |
| () Diabetes Type I or II | () Tuberculosis |
| () Heart murmur | () Hepatitis Type _____ |
| * Do you have mitral valve prolapse? Y N | () Phlebitis (blood clot) |
| If so, do you require antibiotics? Y N | () 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: _____

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?

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Basal body temperature | <input type="checkbox"/> Infection test (ureaplasma, mycoplasma) | <input type="checkbox"/> Estradiol |
| <input type="checkbox"/> Post coital test | <input type="checkbox"/> Endometrial biopsy | <input type="checkbox"/> FSH |
| <input type="checkbox"/> Clomid challenge test | <input type="checkbox"/> Hysterosalpingogram | <input type="checkbox"/> DHEAS |
| <input type="checkbox"/> Sonohysterogram | <input type="checkbox"/> Antibody tests | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Testosterone | <input type="checkbox"/> Ultrasound | |

Have you ever taken any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Clomid | <input type="checkbox"/> Letrozole | <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: _____