		Age:	**Date**:
DOB:	**Race**:	**Occupation**:	**Marital Status**:
How were you referred to our office?	□ Friend/Relative: _____ □ Doctor: _____ □ Insurance Co □ Yellow Pages □ Referral Service □ Internet □ Other: _____		

REASONS FOR TODAY'S VISIST: Check all that apply

□ Well Woman (no complaints, problems, or medications needs) □ Annual with refill or medication □ Fibroids
□ Abnormal bleeding □ Ovarian Cyst
□ Referred by internist/doctor: _____ For: _____
□ Second Surgical opinion Current OB/GYN: _____ Proposed Surgery: _____
□ Annual With problems: _____
_____
_____
_____
_____

List all the doctors that you consider to be involved with your health care and medical care:

Primary doctor	ENT	Internist	Psychiatrist
Derm	GI	Kidney	Surgeons
Endo	Heme & Onc	Neurology	Urologist

CONTRACEPTION: What method do you use to prevent pregnancy?

	Abstains		Depo Provera		Infertility		Menopause		NuvaRing		Trying for pregnancy
	Birth Control Pills		Diaphragm		IUD		Natural family planning		OrthoEvra		Tubal ligation (BTL)
	Condom/Foam		Female Partner		Hysterectomy		Norplant		Rythm		Vasecotomy

Migraines or deep vein thrombosis (blood clots) with birth control pills? [] Yes [] No
_____
_____

MARITAL /RELATIONSHIP HISTORY

□ Single	Partner's Name:	□ Life Partner _____ years
□ Married _____ years		□ Divorced for _____ years
□ Engaged	Partner's DOB:	□ Separated
□ Widowed _____ years	Partner's Occupation:	□ Living with significant other

GYNECOLOGIC AND YEARLY SCREENS

	Date	Location/Doctor	Result	
Last Pap Smear			□ Normal □ Abnormal	Follow up:
Last Mammogram			□ Normal □ Abnormal	Follow up:
Bone Density			□ Normal □ Abnormal	Follow up:
Colonoscopy			□ Normal □ Abnormal	Follow up:
Stress test			□ Normal □ Abnormal	Follow up:
CHOL/DM check			□ Normal □ Abnormal	Follow up:

PREVENTIVE HEAL AND SOCIAL HISTORY

Smoking	□ Yes	□ No	Have you tried to quit smoking? □ Yes, date: _____ □ No	# of years smoking: _____	Packs per day: __
Alcohol	□ Yes	□ No	□ 2 or 3 times a week □ Daily □Socially		
Illicit Drug	□ Yes	□ No			

PRESCRIPTION: Herbal, Over the counter vitamins, supplements, Meds and holistic medications.

Drug (include dosage and schedule)	Reason Taking	Prescribing Doctor

ALLERGIES TO MEDICATION

Drug	Type of Reaction			Drug	Type of Reaction		
	Rash	Swelling	Short of breath		Rash	Swelling	Short of breath

Name: _____ **Date**:_____

MENSTRUAL HISTORY: Skip this table if you are no longer having cycles (any bleeding) due to hysterectomy

Age at first menstrual cycle	□ _____ □ I started my cycle spontaneously □ I needed meds to start □ I have not started
Menstrual Cycles	□ I have stopped having cycles □ I missed my last cycle □ I have missed more that one cycle □ non due to pill □ "Non-Cyclic"
# of days between cycles	□ 21-30 □ <19 days □ >35 □ Irregular □Vary by weeks or months unpredictable
Menstrual flow	□ Normal □ Normal with pill □ Abnormal (please see "Abnormal cycles or bleeding")
# of pads/ tampons used (heavy days) per day	□ <10 □ Greater than 10 □ double protection □ double protection with accidents □ Clots □ Other
# of days bleeding	□ 2-5 days □ >5 days □ Starts and stops □ Bleeding is continual/ non-stop □ Spotting pre/post menstrual □ Other

MENSTRUAL CRAMPS (painful periods) □ No □ Yes, if yes please complete the section below

Nature of Pain	□ Mild □ Moderate □ Severe □ Achy □ Sharp □ Dull □ Throbbing □ Piercing □ Knife-like □ Burning □ Comes and goes □ Continuous
Pain starts	□ 1 or 2 days before cycle □ With the onset of bleeding □ After cycle □ Starts with cycle but remains after
Pain awakens you from sleep	□ Yes
Pain relief	Requiring: □ Bed rest □ Non-Prescription medication □ Prescription Medication
Altered ADL 2 º pain	□ Yes □ Rare or occasional □ Frequently □ Always (at least one day) □ Prevents intercourse

ABNORMAL CYCLES OR BLEEDING □ No □ Yes, if yes please complete the section below

How long have you had this problem?	□ Last cycle □ Last few weeks □ 0-3 months □ 3-6 months
Nature of bleeding	□ Spotting or staining □ Clots □ Flooding □ Soil clothes / sheets □ House bound due to bleeding
When during the cycle does it occur?	□ Unpredictable □ Pre-menstrual □ In-between periods □ After I have finished my cycle □ After intercourse
Medical intervention	□ Changed pills □ Double-up OCP □ Changed Hormones □ Progesterone □ Estrogen □ Depo Provera □ Depo Lupron
Bleeding after intercourse	□ Recent onset X 1 □ Recently several episodes □ Always □ In past □ Last episode: _____

_____
_____
_____
_____

ABDOMINAL/PELVIC/SPINE: □ No □ Yes

Location of Pain	Where do you hurt? _____
When did you first notice this pain?	□ Last few hours □ Last 24 hours □ Last few days □ Last few weeks □ Months □ 6+ months □ Years
What makes the pain worse?	□ Nothing □ Working □ Sleeping □ Intercourse □ Having a bowel movement □ Exercising □ Eating
Does the pain more or "shoot" to other parts of your body?	□ No □ Yes, where? _____
Prior medical Evaluation	□ No □ Yes, where? _____
	□ X-Rays □ Sonograms/ultrasound □ CT □ MRI □ Barium enema □ GI w / u
Medical Condition	□ Adhesions □ Celiac Sprue □ Colitis □ Diverticulitis □ Diverticulosis □ Endometriosis □ Fibroids □ Gallbladder disease/ stones □ H. pylori (stomach ulcers) □ Hepatitis □ Herniated disc □ IBS (irritable bowel) □ Nerve Damage □ Osteoarthritis □ Ovarian Cysts □ Pancreatitis □ Pelvic infections □ Infection in uterus/tubes "PID" □ Kidney Infection □ GERD □ Kidney stones □ Shingles □ Spinal disc disease □ Spondylosis □ Sciatica □ Surgical or post surgical pain
Do you miss work/school due to pain?	□ No □ Yes □ Rare □ Frequently □ Daily
Rate pain	□ 0-3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
Nature of pain	□ Achy □ Sharp □ Dull □ Throbbing □ Piercing □ Knife-like □ Burning □ Comes and goes □ Continuous
How long does the pain last?	□ Seconds □ Minutes □ Hours □ Days □ Varies □ Continual
Nausea/vomiting associated with pain?	□ Yes, nausea only □ Yes, nausea and vomiting □ Yes, severe vomiting

GERNERAL BODY SYMPTOMS

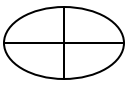
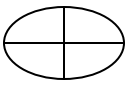
Recently lost weight without dieting?	□ No □ Yes, how much? _____ Over what period of time? _____
Fever	□ Low grade (<100.4º) □ High > 100.4º
Night sweats	□ No □ Yes
Blood in urine	□ No □ Yes, when? _____
Food intolerance or allergy?	□ No □ Yes, what? _____
Does it hurt to have a bowel movement?	□ No □ Yes
Change in bowel movement?	□ No □ Yes, describe: _____
Abdominal bloating or distention	□ No □ Yes □ Occasionally □ Frequently □ Severe
Diarrhea	□ No □ Yes, how many stools per day? _____ Are they water? □ Yes □ No
Constipation (<a BM every 1-2 days)	□ No □ Yes, daily □ Yes, daily laxative
Mucus or blood in stool?	□ No □ Yes, when did this last occur? _____ How often does it happen? _____

Name: _____ **Date**: _____

EMOTIONAL HEALTH Are you seeing or want to see a Psychiatrist/MD/Therapist for any problems? □ No □ Yes_____ □ Want to be referred

Sleep disturbance	□ No	□ Yes insomnia □ Yes early waking □ Yes difficulty falling asleep due to problems □ Yes excessive sleep				
Unexplained weight loss	□ No	□ Yes		Suicide thoughts or plans	□ No	□ Yes _____
Unexplained weight gain	□ No	□ Yes		Excessive relationship of family stress	□ No	□ Yes _____
Anger	□ No	□ Yes		Excessive work related stress	□ No	□ Yes _____
Fear	□ No	□ Yes		Excessive financial stress	□ No	□ Yes _____
Anxiety / Panic attacks	□ No	□ Yes		Current treatment for anxiety/panic	□ No	□ Yes _____
Mood swings	□ No	□ Yes		Current treatment for bipolar illness	□ No	□ Yes _____
Depressed	□ No	□ Yes		Current treatment for depression	□ No	□ Yes _____

BREAST HEALTH:

Do you understand and perform the self-breast examination?	□ Yes	□ No
Have you had a breast reduction, breast lift, or reconstruction?	□ No	□ Yes, when? _____
Do you have breast implants? □ Saline □ Silicon	□ No	□ Yes, when? _____ Are firm or hard? □ Yes □ No
Do you have fibrocystic breast disease?	□ No	□ Yes
Breast asymmetry (one breast is significantly larger)	□ No	□ Yes □ Right □ Left
Large breast that causes shoulder/back pain?	□ Yes	□ No
Have you felt a lump, cyst, or change in your breast?	□ No	□ Yes, when did you find this? _____
Has the lump, cyst, change in your breast increased/decreased?	□ Yes	□ No
Do you have nipple discharge? □ No □ Yes, only if expressed □ Yes, spontaneous □ Yes, milky □ Yes, green □ Yes, bloody		
Do you have unusual or severe pain/tenderness in your breasts?	□ No	□ Yes □ Right □ Left □ Both
Have you had a breast biopsy?	□ No	□ Yes □ Right □ Left □ When? _____ Dr: _____
What were the results?	□ Benign	□ Atypical □ Pre-cancerous □ Malignant □ Other
Treatments □ N/A □ Lumpectomy □ Mastectomy □ Bilateral □ Sentinal node biopsy □ Lymph notes □ Chemotherapy (IV) □ Radiation □ Tamoxifen / Letrozole		
Please use the diagram to the right to mark the location of any Biopsoies, pain, thickening, cysts, or masses.	X Biopsy C Cyst M Mass T Tenderness P Pain H Thickening	Right  Left 
First degree relative with breast cancer?	□ No	□ Yes □ Mother □ Sister □ 2 Sisters □ 3 Sisters □ Father □ Brother
First degree relative with ovarian cancer?	□ No	□ Yes □ Mother □ Sister □ 2 Sisters □ 3 Sisters □ >3 Sisters
**If you answered yes and or have a strong family history are you familiar with genetic testing, BrCa 1 and 2?		□ Yes □ No □ Need info

VAGINAL INFECTIONS (Frequent, recurrent or currently) □ No □ Yes Duration: _____ Days: _____ Weeks: _____ Months: _____

Describe the discharge	□ Odor □ White □ Grey □ Yellow □ Bloody □ Thick □ Watery □ Cheesy □ Itching □ Irritation □ Burning	
Do you have recurrent vaginal infections? (more than 2-3 a year)	□ No	□ Yes
Do you have burning, throbbing, or swelling in the vulvar area, particularly associated with or after intercourse?	□ No	□ Yes
Do you have vulvar or vaginal sores or raw areas that recur or do not heal?	□ No	□ Yes □ Non-painful □ Painful
Do you use tampons/ thongs/ bubble baths?	□ No	□ Yes (not advised for gynecologic)

ENDOCRINE SYSTEM: (Please check all that apply to you or that you have been treated for in the past.)

Have you or are you being treated for a "hormonal imbalance"?		□ No	□ Yes: What?
Have you or are you being treated for an endocrine problem?		□ No	□ Yes: What?
□ Abnormal hair growth	□ Under Active Thyroid	□ I do not ovulate	□ Insulin Resistance
□ Male pattered balding	□ Overactive thyroid	□ Polycystic ovaries	□ Diabetes Type 1
□ Severe and/ or Adult Acne	□ Goiter	□ Infertility	□ Diabetes Type 2
□ Adrenaline Problem	□ Graves disease	□ Excess Prolactin	□ Parathyroid Disease
□ Excess male hormones	□ Thyroid nodule	□ Ovarian failure	

EXERCISE:

Do you exercise on a regular basis?	□ No □ Yes
How often do you exercise and for how long?	
What type of exercise do you perform?	
Are you able to comfortably exercise? (Without shortness of breath, chest pain, pain in your leg or feeling faint?)	
How many blocks can you walk without being short of breath, having chest discomfort, or leg pain?	
Have you received a cardiology exam for clearance to exercise?	

Name: _____ **Date**: _____

URO-GYNECOLOGY & PELVIC SUPPORT (check those symptoms that apply)

√	Symptom	√	
	Do you recurrent urinary tract infections?		Do you wear daily protection due to leakage?
	Pain with urination or blood in the urine?		Do you loose urine when you cough/sneeze?
	Do you urinate frequently (>6 to 8 times a day)		Do you feel as if you are not able to completely empty bladder
	Do you need to urinate at night (more than 2 times)		Do you have urge?

GI AND BOWEL SYMPTOMS (check those that apply)

√	Symptom	√	
	Do you have daily bowel movement?		Have you had a colonoscopy?
	If not, how many days apart are your bowel movements? _____		When?
	Do you have Crohn's or IBS?		Physician name:

PAP SMEARS

Do you have regular paps?	□ No	□ Yes, when did you start?_____
Have you had an abnormal Pap Smear?	□ No	□ Yes, when? _____ Where? _____
Did you have a Biopsy/Colposcopy?	□ No	□ Yes, when? _____ Where? _____

SEXUAL HISTORY: Do you need help with sexual problems? □ Yes □ No

Are you currently sexually active (have you had intercourse in the last 12 months)?	□ No	□ Yes
I am abstaining by choice (moral, religious)	□ No	□ Yes
I am gay/lesbian	□ N/A	□ Yes

Skip the following table if you have never had sexual relations or would rather not answer

Do you practice safe sex? (condoms, monogamous long term relationship)?	□ Yes					□ No
Sexual history: total # of partners	□ 0-1	□ 2-5	□ 6-10	□ 11-20	□ >21	
Is your sex life happy and fulfilling?	□ Yes	□ No	□ Pain	□ ↓ libido (sex drive)	□ Relationship problems	□ Illness □ Sexual problem
How frequently do you have sex?	□ _____ times per day	□ _____ times per week	□ _____ times per month	□ _____ time per year		
Check all that apply to you and your sexual experience	□ Vaginal intercourse	□ Oral sex	□ Anal sex	□ Other: _____		
Do you have pain with intercourse / making love?	□ No	□ Yes	□ On initial penetration	□ On deep penetration	□ Throughout sex	
Vaginal pain, swelling and/ or burning after intercourse	□ No					□ Yes
Do you bleed after intercourse?	□ No					□ Yes
Do you have a loss of libido (low sex drive)?	□ No					□ Yes
Does your partner have sexual/erectile dysfunction impotency?	□ No					□ Yes

FAMILY VIOLANCE SCREENING

Has anyone hurt you or threatened to hurt you (physical, emotional, or sexual abuse)?	□ No	□ Yes: □ Current □ Past
Do you need information on your rights and community services?	□ No	□ Yes

The abuse of a child carries into adulthood and impacts her entire life. These questions are difficult to answer. Many of my patients feel more comfortable answering these questions in format. If you would rather discuss this privately with Dr Khan, leave this section blank.

MENOPAUSE HISTORY:

When did you go into menopause? _____

Have you used post-menopausal therapy? _____

What medications/over the counter medications have you used? _____

Any post-menopausal bleeding? _____

MENOPAUSE PATIENTS ONLY: Check all that apply

	Hot Flashes		Skin excessively dry		Decreased memory		Vaginal dryness
	Mood Swings/Irritability		Hair loss		Difficulty concentrating		Osteopenia/ Osteoporosis
	Tiredness/ loss of energy		Bifocals		Difficulty learning		Abnormal weigh gain
	Insomnia/poor sleep		Decreased libido/sex drive		Confusion		Inability to ↓ weight

_____

_____

_____

_____

_____

Name: _____ **Date**: _____

MEDICAL, SURGICAL & OBSTETRICAL HISTORY

OBSTERTRICAL HISTORY (INCLUDES ECTOPICS, ABORTIONS, MISCARRIAGES): □ I have never been pregnant □ Adopted kid

Year	Sex	Hospital/Dr	Baby's weight	Vaginal / C / S	Complications

_____
_____

SURGICAL / HOSPITALIZATION: List ***all*** hospitalizations requiring medical admissions, and/or emergency treatment. List ***all*** surgical procedures. Include office surgeries such as LEEP, Cones, Colonoscopy, Bronchoscopy, Eye surgeries etc. the more complete the better.

Year	Doctor/Hospital	Reason/ Illness/ Surgery/ Complications

_____
_____
_____
_____

MEDICAL HISTORY: Type of problem / Duration / Current status

Asthma	Hyper cholesterol
Blood Transfer	Kidney DX
Cancer	Liver DX
CVA	Lupus
DM	Migraine
DVT	MVP
HTN	Thyroid DX

_____
_____
_____

FAMILY HISTORY PARENTS AND SIBLINGS: □ I do not have any information on my family □ I am adopted

	Age			Diseases / illness / Causes of Death
Mother		□ Living	□ Deceased @_____ age	
Father		□ Living	□ Deceased @_____ age	
Sister(s)		□ Living	□ Deceased @_____ age	
Brother(s)		□ Living	□ Deceased @_____ age	

_____
_____

FAMILY HISTORY OF CANCER: □ I have no family history of cancer

Cancer	Breast	Uterine	Ovarian	Colon	Lung	Melanoma	Age diagnosed	Current Age	Age @ Death	Office Use Only
Self										
Mother										
Father										
Sister										
Brother										
Grandmother										
Grandfather										
Aunt										
Uncle										
Other										

Name: _____ **Date**: _____

VACCINATION HISTORY: Check the vaccinations that you have been given.

Vaccine Given	√	Date Given	Given By
Hep. A&B			
Gardasil			
TDAP			

NUTRITION, WEIGHT, AND GENERAL SAFETY CONCERNS

DIET & SUPPLEMENTS		GENERAL RECOMMENDATIONS	WEIGHT	
Multivitamins & 1mg Folic	Recommended		15 over IBW	Risk for obesity
Caffeine beverages	Limit 1-2 per day	Dental exams 3-6 months	10 lb. Weight gain once/yr	Risk for obesity
Calcium & Vitamin D	1500 mgs daily	Fire extinguisher/safety plan	22lb. Gain since age 18	Risk for obesity
↓fat, cholesterol, calorie	Diets are available	Seat belts	<15 under IBW	Risk for eating disorder

PREVENTIVE MEDICINE Please **read and then initial each and every item**. Your initial will indicate that you have read, understood and agreed to these immunization guidelines.

			Initial
Flu	Viral illness	Recommended for all ♀ >50 years old & ♀ with chronic diseases	
Pneumococcus	Pneumonia	Recommended for ♀ 65 years +, and people with chronic illness.	
MMR	Measles, Mumps, and Rubella	Childhood immunization does not always last a lifetime.	
Hep B	Hepatitis B	Series of three injections	
Hep A	Hepatitis A	Travelers, daycare, heath care providers.	
Varicella	Chicken Pox	Recommended if you didn't have childhood disease, not immune.	
TDAP	Tetanus	Booster every 10 years	

SUBSTANCE USE AND ABUSE: Please read and then initial each and every item. Your initial will indicate that you have read, understood, AND agreed to these guidelines.

			Initial
Smoking:	Cancers: lung, vulvar, bladder, throat, etc. Heart disease, Emphysema, COPD, and other debilitatingm potentially Fatal illnesses. Infertility, premature birth, intrauterine Growth, retardation.	Smoking cessation guidelines and assistance at quitting this harmful habit are available.	
Alcohol:	Excessive alcohol intake is harmful. Alcohol-related illness include liver disease, liver cancer, colon cancer, Alcoholism, birth defects, breast cancer, and a variety of other medical illnesses.	Assistance at sobriety will be made available.	
Drugs:	The use of illicit drug is harmful and can/will lead to serious medical problems. The adverse health related problems with this illegal behavior include, but are not limited to, hepatitis, AIDS, infections, and death.	Assistance and appropriate referrals are available.	

HEALTH AND CANCER SCREENS: Initial

Mammograms	A baseline mammogram and then yearly thereafter is required. If you have a positive family history of breast cancer, a mammogram should be preformed 10 years prior to the age that your family was diagnosed.	Scheduling information will be Given to you and it is your responsibility to schedule this cancer-screening test.	
Cholesterol	Cholesterol and triglycerides should be evaluated on a regular basis. The frequency of this testing is individualized. Many insurance companies do not pay for elective testing.	If you wish to have your cholesterol checked please notify your nurse.	
Heart Disease Screening	Women are particularly susceptible to heart disease because their symptoms are often vague and under-reported. The early diagnosis and management of heart disease is priority.	Referral for testing and management is available.	
Osteoporosis screening	Menopausal patients are asked to obtain a bone density study. Osteoporosis is asymptomatic for years, until the patients had a fracture. Mortality of hip fracture is 25% in the first year.	Yearly screening for patients who are at high risk or have a + family history.	
Colon Cancer	Screening begins at age 50 with yearly rectal exams and Hemoccult. (A rectal exam is a part of every pelvic exam for every patient.) At age 50, a colonoscopy will be recommended. If you have family history of colon cancer, this will be started earlier and preformed at frequent intervals.	Referrals will be made and Guidelines reviewed.	