MEDICAL HISTORY-CONSULT

Name: _____Birthdate:_____Date:_____

PATIENT PREFERENCES:

Primary Care Physician: _____Who referred you to our office? _____

Local Pharmacy and Phone Number: _____

Mail Order Pharmacy: _____

Imaging Center: Gwinnett Medical Center Eastside Emory John's Creek Breast Care Specialists
Northeast Georgia _____ Northside _____ Other_____

REASON FOR VISIT: Check all that apply.

- ○ **Pelvic pain**
- ○ **Abdominal pain**
- ○ **Vaginal pain/problem**
- ○ **Vulvar pain/problem**
- ○ **Pain with intercourse**
- ○ **Frequent UTI's**
- ○ **Frequency**
- ○ **Other_____**

If you are here for abdominal or pelvic pain

Where is the pain? Please circle all that apply

Right Left Both/Bilateral Unsure
Upper Lower Suprapubic Midline Other:_____

Which of the following best describe the pain? Please circle all that apply

Sharp Shooting Stabbing Dull Achy Pressure Spasmodic Burning Fullness/Bloating Radiating Other_____

REVIEW OF SYSTEMS: Please circle any of these symptoms that you are currently experiencing.

CONSTITUTIONAL: fever, chills
GASTROINTESTINAL: abdominal pain, epigastric pain, nausea, vomiting, constipation, diarrhea, rectal bleeding, rectal pain, leaking or stool
GENITOURINARY: bladder pain, urethral pain, urinary urgency, urinary frequency (urinating more than 8 times a day), pain with urination, blood in urine, getting up at night to urinate, leaking urine, vaginal pain, vulvar pain, vaginal discharge, vaginal odor, vaginal itching, vaginal burning, vaginal irritation, lesions, bleeding
SEXUAL: painful intercourse (deep), painful intercourse (upon penetration), vaginal dryness
MUSCULOSKELETAL: lower back pain, upper back pain, thigh pain, groin pain

ALLERGIES: Please list any drug allergies.

- ○ **None**
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

MEDICATIONS: Please list any medications that you take: prescription, over the counter, and vitamins.
IF YOU HAVE A LIST OF MEDICATIONS WITH YOU PLEASE ASK THE FRONT DESK TO MAKE A COPY AND SKIP THIS SECTION.

Name	Dosage	How often

HEALTH MAINTENANCE TESTING	DATE	RESULTS	LOCATION
MAMMOGRAM			
COLONOSCOPY			
BONE DENSITY			
PAP SMEAR			
GENETIC TESTING			

1. **Have you ever had an abnormal pap smear? _____**
2. **Are you sexually active? _____**
   a. **If no, have you ever been sexually active? _____**
   b. **If yes, have you had any new sexual partners _____**
3. **Sexual orientation: (please circle one) Heterosexual Bisexual Homosexual Transgender**
4. **What do you use for contraception (to prevent pregnancy)? _____**
5. **Do you desire STD testing today? _____**

MENSTRUATING WOMEN ONLY:

First day of last period_____ Length of flow: _____ Monthly cycles: YES or NO

Amount of bleeding: (please circle one) SCANT / LIGHT / MODERATE / HEAVY

1) **# of heavy days: _____**
2) **How old were you when you started your period? _____**
3) **Have you had the HPV/Gardasil vaccination? _____**

MENOPAUSAL WOMEN ONLY:

Age at menopause: _____

Hormone replacement therapy: (please circle one) NEVER / CURRENT / PAST USE

Have you had any bleeding in the last year? _____

OB HISTORY: Tell us about your pregnancies.

Never Pregnant Number of Pregnancies_____ Number of Deliveries_____

Date	**Outcome:** *Please circle*	**Delivery type:** *please circle*
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section
	Full term / Preterm /Stillbirth /Miscarriage/Termination/Ectopic	Vaginal/C-section

FAMILY HISTORY: Please circle any of the following that affect a family member, indicate relationship (i.e. Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle) and if they are maternal or paternal.

Disease	Family Member
Breast cancer	
Uterine cancer	
Colon/Rectal cancer	
Ovarian cancer	
Prostate cancer	
Has anyone in the family had genetic testing?	
Heart disease	
High blood pressure	
Stroke	
Thyroid disease	
Diabetes	
Osteoporosis	
Bleeding/Coagulation disorder	
Fibromyalgia	
Depression	
Endometriosis	
Chronic pelvic pain	
Interstitial cystitis	
Irritable bowel	

SOCIAL HISTORY: Please answer ALL questions. Circle the one that applies to you or fill in the blank.

Smoking
1. Never/Current/ Past Use
   -> How many cigarettes daily? _____
2. Would like to quit? Yes/No

Alcohol Use:
1. Never/Occasional/ Moderate/Heavy
2. History of alcohol abuse? Yes/ No
3. How many days in the last year have you had more than 4 drinks in one day? ____

Drug Use:
1. Never / Current Use / Past Use
2. Rehab: Current / Past / Never

Country of Birth: _____

Ethnic Background:
1. Caucasian
3. African American
4. Latin
5. Native American
6. Asian
7. Pacific Islander
8. Jewish
9. Mediterranean
10. Eastern Europe
11. Western Europe
12. French Canadian
13. Other:_____

Occupation: _____

Religion: _____

Marital Status
1. Single/ Domestic Partner/ Married/Separated/Divorced/ Widow

Domestic Violence:
1. Do you feel safe at home? Yes/No
2. Do you have a history of emotional/physical/sexual abuse? Yes/No

Hobbies/Activities: _____

Stress Level:
1. Low/Medium/High

SURGICAL HISTORY:		
Date	**Type of Surgery (Please circle those done for pain)**	**Surgeon**

Have you ever been hospitalized for anything other than childbirth? Y/N Explain: _____

Have you had major accidents such as fall or back injury? Y/N Explain: _____

MEDICAL HISTORY: Please check any medical problems

CANCER (List Type)
- ○ _____
- ○ _____
- ○ _____

HEART DISEASE
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Heart Attack
- ○ Cardiomyopathy
- ○ Murmur
- ○ Pacemaker/Defibrillator

DERMATOLOGY
- ○ Eczema
- ○ Rosacea
- ○ Vitiligo

ENT
- ○ Meniere's Disease
- ○ Tinnitus
- ○ Hearing Loss
- ○ Sleep Apnea

ENDOCRINE
- ○ Diabetes
- ○ Osteopenia
- ○ Osteoporosis
- ○ Thyroid Problems

GI
- ○ Colon Polyps
- ○ Irritable Bowel Syndrome
- ○ Acid Reflux

GYNECOLOGY
- ○ Dysplasia
- ○ Endometriosis
- ○ Fibroids
- ○ Infertility
- ○ PCOS

HEMATOLOGY
- ○ Von Willebrand Disease
- ○ Factor V Leiden
- ○ Coagulation Disorder
- ○ DVT/Pulmonary Embolism
- ○ Sickle Cell Disease/Trait

INFECTIOUS DISEASE
- ○ HIV
- ○ Hepatitis
- ○ Herpes
- ○ HPV
- ○ MRSA Infection

NEUROLOGIC
- ○ Migraine
- ○ Mental Retardation
- ○ Autism
- ○ Multiple Sclerosis
- ○ Parkinson's
- ○ Neuropathy
- ○ Seizures

ORTHOPEDIC
- ○ Osteoarthritis

PSYCHIATRIC
- ○ ADD
- ○ Anxiety
- ○ Depression
- ○ Insomnia
- ○ Bipolar Disorder
- ○ OCD
- ○ PMS
- ○ Anorexia

PULMONARY
- ○ Asthma
- ○ Seasonal Allergies
- ○ Pulmonary Fibrosis
- ○ Emphysema
- ○ COPD

RHEUMATOLOGY
- ○ Fibromyalgia
- ○ Lupus
- ○ Gout
- ○ Raynaud's Disease
- ○ Sjogren Syndrome
- ○ Scleroderma
- ○ Chronic Fatigue Syndrome
- ○ Psoriasis
- ○ Rheumatoid Arthritis

UROLOGY
- ○ Kidney Stones
- ○ Interstitial Cystitis
- ○ Over Active Bladder

OTHER
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

DIAGNOSTIC TESTING: Please mark the evaluation and testing that you have had for your problem and use the blanks to give us dates, providers, or any pertinent information.

CULTURES
- ○ **Vaginal cultures**
- ○ **Urine cultures**
- ○ **Cervical cultures**
- ○ _____

RADIOLOGY STUDIES
- ○ **Ultrasound**
- ○ **CT Scan**
- ○ **MRI**
- ○ _____

GYNECOLOGIC EVALUATION
- ○ **Endometrial biopsy**
- ○ **Hysteroscopy**
- ○ **D&C**
- ○ **Laparoscopy**
- ○ _____

PRIMARY CARE PROVIDER
- ○ _____
- ○ _____

GASTROENTEROLOGY EVALUATION
- ○ **Endoscopy**
- ○ **Colonoscopy**
- ○ _____

UROLOGY EVALUATION
- ○ **Cystoscopy**
- ○ **Urodynamics**
- ○ **Potassium sensitivity**
- ○ **Hydrodistention**
- ○ _____

ORTHOPEDIC EVALUATION
- ○ _____
- ○ _____

RHEUMATOLOGY EVALUATION
- ○ _____
- ○ _____

NEUROLOGY EVALUATION
- ○ _____
- ○ _____
- ○ _____
- ○ _____

PSYCHIATRIC EVALUATION
- ○ _____
- ○ _____

INFECTIOUS DISEASE EVALUATION
- ○ _____
- ○ _____

PAIN MANAGEMENT EVALUATION
- ○ _____
- ○ _____

PHYSICAL THERAPY EVALUATION
- ○ _____
- ○ _____

OTHER
- ○ _____
- ○ _____
- ○ _____
- ○ _____

PREVIOUS TREATMENTS: Circle those treatments you have used in the past.

ANTI-SEIZURE MEDICATION
- amitriptyline
- lyrica
- gabapentin/neurontin

ANTIHISTAMINES
- atarax/hydroxyzine
- benedryl
- zyrtec
- _____

ANTI-AXIETY
- valium
- ativan
- xanax
- _____

ANTIDEPRESSANTS
- duloxitine/cymbalta
- fluoxetine/prozac
- sertraline/zoloft
- wellbutrin/ buproprion
- celexa/lexapro
- _____

ANTIBIOTICS
- ciprofloxin
- bactrim
- macrobid
- keflex
- _____
- _____

BLADDER MEDICATIONS
- pyridium/phenazopyridine
- UTA/Uribel/ Urogesic
- Elmiron
- Cystoprotek
- Aloe Vera
- Dessert Harvest

UROLOGY
- Bladder instillations
- Urethral dilation
- Hydrodistention
- Interstim
- Botox
- Tibial nerve stimulation (UrgentPC)

GYNECOLOGY
- Lupron
- Birth control pills/ patch/ring
- IUD _____
- Nexplanon
- Depo provera
- Danazol
- estrogen
- progesterone
- lubricants/moisturizers
- vulvar medications: lidocaine, gabapentin _____
- vaginal medications: flagyl/difucan/monistat
- Other_____

PAIN MEDICATION
- tylenol/acetomenophin
- motrin/ibuprofen/ anaprox/_____
- ultram
- narcotics/percocet/ norco/_____ _____

PHYSICAL THERAPY
- Biofeedback
- Pelvic floor relaxation
- Trigger point injections
- Massage
- TENS unit/electrical stimulation
- Dilators
- Dry needling
- _____

OTHER
- Accupuncture
- Diet
- Meditation
- Exercise
- Herbal medicine _____
- Homeopathic medicine_____ _____
- Nerve block

MODIFYING FACTORS: Please look at the following list and mark if you have noted whether there is improvement

	HAVE NOT NOTICED/TRIED	IMPROVES/HELPS	MAKES IT WORSE
Meditation			
Massage			
Pain medication			
Relaxation			
Ice			
Heat			
Full bladder			
Urination			
Empty bladder			
Bowel movement			
Laxative/enema			
Rest			
Activity/exercise/movement			
intercourse			
orgasm			
Contact with clothing			
Stress			
Interstitial cystitis			
Allergies			
Diet/certain foods or beverages			
Other:			