



DUKE UROGYNECOLOGY HISTORY FORM

The following questions will help us understand your medical and family history and your current medical concerns.
Please complete and bring with you to your doctor's appointment.

Today's Date: _____

Your Name: _____ Birth Date: _____ Age: _____ Medical Record #: _____

Do you identify yourself as: Caucasian African American Hispanic Asian Other (Circle One)

Why are you seeing the doctor? _____

Medical History: Do you have any of the following problems? Please check yes or no and explain as needed.

	No	Yes	
Diabetes			
Heart Disease			
Hypertension			
Stomach or Bowel Problems			
Depression			
Liver Problems			
Thyroid Problems			
Bone, Joint, Muscle Problems			
Bleeding Disorder			
Neurologic Problems (seizure, headaches, weakness)			
Circulation Problems			
Cancer (If yes, what type?)			

Surgical History: (Please circle yes or no. Include dates and types of surgery and describe fully).

Hysterectomy (removal of your uterus) No Yes _____
Vaginal Abdominal (circle one)

Removal of Ovaries No Yes _____

Bladder Surgery No Yes _____

Blood Transfusion No Yes _____

Other Surgeries No Yes _____

Gyn History: (Please circle your answer. If necessary, more than one answer may be circled for each question).

How long has it been since your last menstrual period? 1 month 6 months 1 year longer Date of last period _____

If you still have periods, are they: Regular Irregular, Heavy Moderate Light, Painful

When was your last Pap smear? _____ Normal Abnormal

When was your last mammogram? _____ Normal Abnormal

Have you had a colonoscopy? If so, date _____ Normal Abnormal

If you are taking hormones, please list them: _____

Are you using any form of birth control now? Yes (type) _____ No

Number of Pregnancies _____ Number of Live Births _____

How many vaginal deliveries have you had? _____ How much did your largest vaginally delivered baby weigh? _____

How many Cesarean deliveries have you had? _____ Why did you have a Cesarean? _____

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Social History: (Please circle yes or no).

Do you use tobacco? Yes No If yes, daily amount _____ Number of years _____
Do you drink alcoholic beverages? Yes No If yes, daily amount _____
Are you in a sexual relationship? Yes No If yes, is your sexual partner(s) Male Female Both
Is sexual intercourse an important consideration in how we manage your problem? Yes No
Are you physically active? Yes No What do you do? _____

Family History: (Check any illness that any blood relative has had and write in that person's relationship to you).

____ Ovarian Cancer _____
____ Colon Cancer _____
____ Breast Cancer _____
____ Other Cancer _____
____ Heart Disease _____
____ Diabetes _____
____ Other Diseases _____

Does any woman in your family have problems with urinary or bowel control or pelvic support problems? Yes No Unknown

Medications: (Please list all medications with the dose and include prescriptions, over-the-counter medications, vitamins, supplements, etc.)

Are you allergic to any medications? Yes No (If yes, please list the medication(s) and the type(s) of reactions to them).

Do you currently have any of the following symptoms? (Circle any and all that apply and describe in the space provided).

General: Fever Fatigue Irritability Sleep Changes Anxiety Depression Other

Head/Ears

Nose/Mouth/Throat: Headache Sore Throat Hearing Loss Ear Pain Other

Blood/Lymphatic: Easy Bruising Bleeding from Gums Swollen Glands Other

Heart: Chest Pain Shortness of Breath with Exertion Pain in Lower Legs with Walking Other

Lungs: Difficulty Breathing Wheezing Cough Sputum Production Other

Gastrointestinal: Diarrhea Constipation Nausea Vomiting Abdominal Pain Other

Neurologic: Dizziness Tingling or Numbness Weakness Visual Changes Other

Allergic: Sensitivity to Foods/Pets Seasonal Symptoms Frequent Colds/Flu Other

Musculoskeletal: Pain in Muscles/Joints Limited Mobility Difficulty Walking Swelling Other

Skin/Hair: Rash Dryness Excess Hair Growth Hair Loss Other

Female: Painful or Difficult Sex Vaginal Dryness Vaginal Discharge Breast Discharge Other

