CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: Date:

MEDICAL HISTORY

Please **check** all that apply: □ I have no medical problems – go to next section.

	Self	Siblings	Mom	Dad	GPs		Self	Siblings	Mom	Dad	GPs
ADD/ADHD/ASD	□	□	□	□	□	Hepatitis A, B, C	□	□	□	□	□
Alcohol	□	□	□	□	□	HIV/AIDS	□	□	□	□	□
Alzheimer's Disease	□	□	□	□	□	Hypothyroidism/Hashimotos	□	□	□	□	□
Anxiety	□	□	□	□	□	High Blood Pressure	□	□	□	□	□
Arthritis	□	□	□	□	□	Hyperthyroidism/Graves/Goiter	□	□	□	□	□
Asthma	□	□	□	□	□	High Cholesterol	□	□	□	□	□
Atrial Fibrillation/Arryhthmia	□	□	□	□	□	Immune System- Weak	□	□	□	□	□
Bleeding Disorders _____	□	□	□	□	□	Irritable Bowel Syndrome	□	□	□	□	□
Cancer _____	□	□	□	□	□	Kidney Disease _____	□	□	□	□	□
Cervical Disc Disease	□	□	□	□	□	Lung Disease _____	□	□	□	□	□
Chronic Cough/COPD	□	□	□	□	□	Lupus	□	□	□	□	□
Chronic Fatigue	□	□	□	□	□	Lumbar Disc Disease	□	□	□	□	□
Colitis	□	□	□	□	□	Mental Illness _____	□	□	□	□	□
Deep Vein Thrombosis	□	□	□	□	□	Multiple Sclerosis	□	□	□	□	□
Depression	□	□	□	□	□	MI /Heart Attack	□	□	□	□	□
Diabetes	□	□	□	□	□	Osteoporosis/osteopenia	□	□	□	□	□
Drug Addiction	□	□	□	□	□	Rheumatic Fever	□	□	□	□	□
Eye Conditions _____	□	□	□	□	□	Renal/Kidney Stones	□	□	□	□	□
Fibromyalgia	□	□	□	□	□	Seizures	□	□	□	□	□
Gall Bladder Disease	□	□	□	□	□	Sexually Transmitted Infections	□	□	□	□	□
Gastroesophageal Reflux/Ulcer	□	□	□	□	□	Shingles	□	□	□	□	□
Glaucoma (narrow/wide angle)	□	□	□	□	□	Skin Disorder	□	□	□	□	□
Headaches/Migraines	□	□	□	□	□	Sleep Disorder/Apnea	□	□	□	□	□
Heart Disease _____	□	□	□	□	□	Spinal Cord Injury	□	□	□	□	□
Heart Valves	□	□	□	□	□	Stroke/TIA	□	□	□	□	□
Hemorrhoids	□	□	□	□	□	Varicose Veins	□	□	□	□	□
						Other_____	□	□	□	□	□

SURGICAL HISTORY

Please **circle** any surgeries that you have had indicate **year**: □ I have never had surgery- go to next section.

Abdominal Surgery _____
Appendectomy
Abdominoplasty/tummy tuck
Anal/Rectal Surgery_____
Back Surgery _____
Breast Implants
Breast Surgery (Lumpectomy R/L, Mastectomy R/L)
CABG _____ x Vessels
Cervical conization/LEEP
Cesarean Section (how many _____)
Cholecystectomy (removal of the gallbladder)
Cystocele Repair/Anterior Repair (w/graft- natural or mesh)
Dilation & Curettage /Endometrial Ablation
Endometriosis Surgery
Facial Surgery _____
Hernia Surgery
Hip Surgery _____Replacement R/L
Hysterectomy, for _____
Abdominal (open) Robotic Laparoscopic Vaginal
Knee Surgery_____ Replacement R/L
Laparoscopy, for_____
Labial Surgery
Pacemaker
Prolapse Surgery (w/graft- natural or mesh)
Removal of Adhesions
Removal of Tubes and Ovaries (R/L or Both)
Sling Surgery
Spinal Stimulator/ InterStim
Other _____

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: Date:

MEDICATIONS Please **list all** current medications, vitamins, supplements If you have a list please provide			
Name	Dosage	How often	Reason for Medication

ALLERGIES Please **list all** allergies, including drugs, iodine, shellfish, latex □ **I have no Drug Allergies**	

SOCIAL HISTORY

Occupation: □ Not currently working outside the home □ Retired □ Working---Vocation_____

Relationship Status: □ Single □ Partnered □ Married, happily- Yes or No □ Separated □ Divorced □ Widowed

Tobacco: □ I have never smoked - go to next section.
□ Quit smoking < 5 years ago 5-10 years ago > 10 years ago
Number of Years using Tobacco _____ Number of Cigarettes per day _____

Alcohol: □ I never drink alcohol - go to next section. □ Drinks per day _____ □ Drinks per week _____

Do you or have you used any of the following:
□ CBD products (edibles, CBD oil, smoking, or topicals) □ Stimulants (cocaine, Adderall) □ Injectables (Heroin)
□ Medications not prescribed to you (opioids (Percocet or Vicodin), sedatives (Valium or Xanax)

GYNECOLOGIC HISTORY

Menstrual History	**Cervical Cancer Screening**	**Pregnancy History**	**Contraceptive History**
Do you still have menstrual periods? If No- why: □ Menopause □ Hysterectomy □ Ablation □ Mirena IUD □ OCPs Date of last menstrual period (MM/DD/YY)_____ Are your periods? □ Regular □ Heavy □ Irregular □ Painful Do you take Hormone Therapy? Yes or No Type: _____ □ I have questions about HT	Have you ever had an abnormal pap? Yes or No Have you had treatment for an abnormal pap? If so: When _____ What treatment _____ Have you had the HPV vaccine Yes or No **Infection History** Have you ever had? □ Chlamydia □ Gonorrhea □ Recurrent yeast □ Herpes □ Recurrent BV □ Other _____	□ I have never been pregnant Number of Total Pregnancies _____ Vaginal Births _____ Cesarean Births _____ Miscarriages _____ Largest Birth _____ Forceps Yes or No Vacuum Yes or No **Sexual History** □ I am not sexually active □ I am sexually active □ I have sexual wellness concerns □ Sexual Orientation □ Heterosexual □ Homosexual □ Bisexual □ Other _____	□ I am not using contraception I have questions about contraception Yes or No Are you using any birth control now? _____ Past use of: □ Abstinence □ barrier method (condom) □ OCP □ IUD mirena/skyla/copper □ Injectable (depo-provera) □ Implant (implanon) □ Nuva ring □ Vasectomy □ Tubal Ligation □ Essure

CENTER FOR
PELVIC HEALTH AND WELLNESS

Patient Name: Date:

REVIEW OF SYSTEMS Please **circle all** symptoms that you currently have **now or in past 2 weeks**:			
Constitutional Chills Fever Weight Gain/Loss Loss of Appetite Fatigue Sleep Disturbance	**Breast** Pain Nipple Discharge Mass Implants	**Respiratory** Cough Shortness of Breath Wheezing/Asthma Use of Inhaler	**Urinary Tract** Frequent Urination Urgency Loss of Urine Frequent Bladder Infections Burning with Urination Blood in Urine Leakage of urine
Eyes Blurred Vision/Double Vision Glasses/Contacts Eye Pain Watery eyes/Itchy Eyes	**Gastrointestinal** Reflux Constipations Diarrhea Nausea/Vomiting Change in Stools Blood in Stools Bloating Stool loss	**Neurologic** Weakness Impaired Balance Headache/Migraines Confusion Numbness/Tingling Memory Loss Brain Fog Learning Disabilities	**Genitourinary** Feeling of Bulge/Vaginal Laxity Vaginal Dryness/Itching Vaginal Discharge Vaginal Mass/Lump Vaginal Pain
Ears/Nose/Throat Dry Mouth Hearing Loss Ringing in the ears Sinus Trouble Sore Throat Denture Use Allergic Symptoms	**Musculoskeletal** Joint Pain Back/Neck Pain Muscle Aches Joint Swelling Fall/Trauma Use of Cane/Walker Tight Muscles Leg Swelling	**Hematologic** Easy Bleeding Easy Bruising Blood Thinners **Endocrine** Increased thirst Changes in Blood Sugars	**Sexual/ Hormone Balance** Lack of Desire Problems with Orgasm Relationship Issues Pain with Intercourse Hot Flashes Night Sweats Mood Swings Weight Problems Brain Fog Forgetfulness Mood Changes Sleep Disturbance
Cardiovascular Chest Pain Palpitations/Irregular heart beat Murmur	**Skin** Rash/Itching Increased Hair Growth Hair Loss Acne/Eczema/Dry skin	**Emotional** Anxiety Panic Attacks Depression Irritability	

HEALTH MAINTENANCE:

	Colonoscopy	Bone Density	Health Screen Lab Tests	Pap Smear	Mammogram
Date of last:	_____	_____	_____	_____	_____