ROCHESTER GYNECOLOGIC AND OBSTETRIC ASSOCIATES, P.C.
CONFIDENTIAL PATIENT HISTORY

Welcome to RGOA. The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____Date_____

Primary Care Physician_____Age_____Birth Date_____

FAMILY HISTORY:

Has anyone in your family had the following: **PLEASE SPECIFY** Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or PGM- Maternal or Paternal), Aunt (A), Uncle (U):

No	Yes	Who		No	Yes	Who		No	Yes	Who	
❑	❑	_____	Blood clots (leg / lung)	❑	❑	_____	High blood pressure	❑	❑	_____	Thyroid disease
❑	❑	_____	Diabetes	❑	❑	_____	Osteoporosis	❑	❑	_____	Tuberculosis
❑	❑	_____	Cancer	❑	❑	_____	Sickle cell disease	❑	❑	_____	Birth defects/hereditary disease
❑	❑	_____	Heart attack	❑	❑	_____	Stroke	❑	❑	_____	Other_____

MEDICAL HISTORY: Do you have, or have you ever had, any of the following:

No	Yes	Now		No	Yes	Now		No	Yes	Now	
❑	❑	❑	Asthma	❑	❑	❑	Heart disease	❑	❑	❑	Positive tuberculosis test (PPD)
❑	❑	❑	Bleeding disorder	❑	❑	❑	Heart murmur	❑	❑	❑	Psychiatric problems
❑	❑	❑	Blood clots (legs/ lungs)	❑	❑	❑	Hepatitis	❑	❑	❑	Recurrent bladder infection (>3 per year)
❑	❑	❑	Breast disease	❑	❑	❑	High blood pressure	❑	❑	❑	Rubella infection or immunization (German measles)
❑	❑	❑	Cancer	❑	❑	❑	High cholesterol	❑	❑	❑	Sickle cell trait or disease
❑	❑	❑	Chicken pox or immunization	❑	❑	❑	HIV exposure	❑	❑	❑	Stroke
❑	❑	❑	Colitis	❑	❑	❑	IBS	❑	❑	❑	Thyroid problem
❑	❑	❑	Diabetes	❑	❑	❑	Kidney problem	❑	❑	❑	Varicose veins/phlebitis
❑	❑	❑	Do you take antibiotics for dental work?	❑	❑	❑	Liver disease/jaundice	❑	❑	❑	Any other illness (please list)
❑	❑	❑	Epilepsy/seizures	❑	❑	❑	Migraine headaches				
❑	❑	❑	Gall bladder problem	❑	❑	❑	Mononucleosis				
❑	❑	❑	GERD (reflux)	❑	❑	❑	Numbness/tingling of extremities				
				❑	❑	❑	Osteoporosis/Osteopenia				

Date of last tetanus shot (month/year)_____

Gardisil vaccine Yes No

MEDICATIONS

List all medications you are using by **NAME AND DOSAGE** (include vitamins, calcium and herbs)

_____

_____

_____

_____

_____

_____

ALLERGIES

❑ No known allergies to medications

Allergies to medications: Please list **name and reaction**:

_____

_____

Are you allergic to: Copper ❑ Yes ❑ No
Rubber/latex ❑ Yes ❑ No
Iodine or shellfish ❑ Yes ❑ No

SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type

MENSTRUAL HISTORY

Age period started_____ Date of last period_____

Periods come every _____ days and last for _____days. Periods are ❑ regular ❑ irregular ❑ light ❑ moderate ❑ heavy.

Do you have cramps with your period? ❑ No ❑ Yes If yes, what do you do for the discomfort_____

Do you bleed between periods? ❑ No ❑ Yes Do you ever use tampons? ❑ No ❑ Yes

GYN HISTORY

Date of last Pap smear_____ Date of last mammogram_____

Date of last DEXA Scan_____ Date of last colonoscopy_____

No	Yes	Now		No	Yes	Now	
❑	❑	❑	Abnormal Pap smear - describe_____	❑	❑	❑	Pain/bleeding with intercourse
❑	❑	❑	Cervical lesions/ biopsy/ cryotherapy /Letz cone	❑	❑	❑	DES exposure (did your mother take DES?)
❑	❑	❑	Unusual vaginal bleeding	❑	❑	❑	PMS symptoms (mood changes, water retention, headaches, etc.)
❑	❑	❑	Abnormalities of the uterus	❑	❑	❑	Tumors/cysts of ovaries
❑	❑	❑	STD (sexually transmitted disease):	❑	❑	❑	Vaginal discharge/infection

❑ chlamydia ❑ genital warts ❑ gonorrhea
❑ herpes ❑ HIV ❑ syphilis ❑ trichomonas

(PLEASE TURN PAGE OVER)

Patient Name_____DOB_____Today's Date_____

PREGNANCY HISTORY

Age of first pregnancy_____ ❑ Never been pregnant Have you ever had difficulty becoming pregnant? ❑ No ❑ Yes ❑ N/A
List number of: Pregnancies_____ Living children_____ Abortions_____ Miscarriages_____

Date of Pregnancies (date of delivery or termination)	Type of Delivery (Vaginal/C-section/VBAC/Termination/Miscarriage)	Sex

CONTRACEPTION

Total number of sexual partners in your lifetime_____
Age of first intercourse_____ Are you sexually active at present? ❑ No ❑ Yes Do you currently have a female partner? ❑ No ❑ Yes
If you have ever used birth control, please list all methods used in the past:

Birth control method	Date(s) of use	Any problems with this method (yes/no)

Present method_____ **Used since**_____ **Any problems (yes/no)**_____

SOCIAL/PERSONAL HISTORY

Marital Status: S M Sep W D Female partner
Calcium: ❒ No ❒ Yes # servings/day (milk, cottage cheese, ice cream, yogurt)
Caffeine: Average #cups coffee/day _____ tea_____ caffeinated soda_____
Tobacco use: ❒ Never ❒ Quit (when)_____ ❒ Currently smoke _____packs/day for how many years_____
Marijuana use: ❒ No ❒ Yes Other street drugs: ❒ No ❒ Yes What?_____
Do you feel you have a problem? ❒ No ❒ Yes
Alcohol: # drinks per week (beer, wine, liquor) _____ How many drinks does it take to feel an effect (to feel high)?_____
Have people annoyed you by criticizing your drinking? ❒ No ❒ Yes Have you ever felt that you ought to cut down on your drinking? ❒ No ❒ Yes
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ❒ No ❒ Yes
Highest year of school completed: 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____City/Country of Birth_____
Occupation_____Employer_____
Have you been exposed to toxic substances? ❒ No ❒ Yes If so, what_____
What do you do for exercise? Type/Frequency:_____
Have you ever been physically, sexually, or emotionally abused? ❒ No ❒ Yes
Present weight is: ❒ Satisfactory ❒ Unsatisfactory Present weight is: ❒ About the same as a year ago ❒ More ❒ Less

REVIEW OF SYSTEMS Are you **currently** experiencing any of the following?

CONSTITUTIONAL			**RESPIRATORY**			**MUSCULOSKELETAL**		
Weight gain > 10lbs	NO	YES	Chronic cough	NO	YES	Joint stiffness	NO	YES
Weight loss > 10lbs	NO	YES	Frequent cough	NO	YES	Joint swelling	NO	YES
Marked fatigue	NO	YES	Shortness of breath	NO	YES	Weakness in muscles	NO	YES
Night sweats	NO	YES	**GASTROINTESTINAL**			Muscle pain	NO	YES
HENT			Difficulty swallowing	NO	YES	Joint pain	NO	YES
Sinus problems	NO	YES	Frequent diarrhea	NO	YES	Back pain	NO	YES
Headaches	NO	YES	Frequent constipation	NO	YES	**PSYCHIATRIC**		
Hearing loss	NO	YES	Blood in stool	NO	YES	Depression	NO	YES
Nose bleeds	NO	YES	**GENITOURINARY**			Anxiety	NO	YES
INTEGUMENTARY (skin, breast)			Frequency	NO	YES			
Breast pain	NO	YES	Urgency	NO	YES			
Breast lump	NO	YES	Pain with urination	NO	YES			
Nipple discharge	NO	YES	Incontinence	NO	YES			
Change in skin color	NO	YES	**NEUROLOGICAL**					
CARDIOVASCULAR			Lightheadedness	NO	YES			
Chest pain	NO	YES	Dizziness	NO	YES			
Irregular heart beat	NO	YES	Numbness/tingling of extremities	NO	YES			
Fainting spells	NO	YES	Problems with coordination	NO	YES			
Swelling of feet or ankles	NO	YES	Tremors	NO	YES			

Do you perform monthly breast self exams (BSE)? ❒ No ❒ Yes Do you use seat belts ❒ No ❒ Yes
Are you interested in HIV (AIDS) testing? ❒ No ❒ Yes
Were you born between 1945 and 1965? ❒ No ❒ Yes If Yes, are you interested in Hepatitis C testing? ❒ No ❒ Yes
Sex: what questions do you have?_____
What concerns do you have to discuss with your health provider?_____