Urogynecology Associates of Philadelphia

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Thank you for taking the time to complete this paperwork. It will help us provide you with the best possible care. We use it to collect relevant medical and social information for input into your electronic medical record. Please complete this paperwork **PRIOR** to your visit. Please bring it with you to your appointment.

NAME:________________________________ DOB:________________________________

Intake History

Reason for visit: ____
Referring Doctor: ____
Primary Care Doctor: ____

OBGYN History

Total number of pregnancies:__________ Abortions: __________
Full Term Births: __________ Living Children: __________
Premature Births: __________ Last Mammogram: __________
Last Pap Smear: __________
Miscarriages: __________
Date of Last Menstrual Period: ________ Length of period: _________ Frequency of periods:_________
Age of Menopause: __________

Current Medications

DRUG	DOSAGE	PURPOSE

For more space, please continue list on back of this paper.

Allergies

TYPE	REACTION

Personal Medical History

Check all that apply:

- ☐ Asthma/Lung Disease
- ☐ Pneumonia
- ☐ Blood Clots/Clotting Disorder
- ☐ Kidney Infections/Stones
- ☐ Tuberculosis
- ☐ Heart Attack/Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Chronic Pain/Fibromyalgia
- ☐ Gallbladder
- ☐ Bladder Infections
- ☐ Cancer, Type: ______________________
- ☐ Reflux/Hiatal Hernia/Ulcers
- ☐ Depression or Anxiety
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Seizures/Convulsions/Epilepsy
- ☐ Bowel Problems
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Hepatitis/Liver disease
- ☐ Thyroid Disease
- ☐ Headaches/Migraines
- ☐ Osteoporosis
- ☐ Other:_________________________

Personal Surgical History

SURGERY	REASON	YEAR

For more space, please continue list on back of this paper.

Family History

	Relative		Relative
Breast Cancer		Colon Cancer	
Uterine Cancer		Diabetes	
Ovarian Cancer		Heart Disease	
Cervical Cancer		High Cholesterol	

Social History

Marital Status:

❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other: ______________________

School Completed:

❑ High School ❑ College ❑ Graduate Degree ❑ Other:__________________________

Occupation:____

Religion:
____

Smoker ❑ Yes ❑ No ❑ Former Packs per day:_____ Age started: _____ Age Quit:_____

Alcohol Use ❑ Yes ❑ No Type: _________ Drinks per day: __________

Drug Use ❑ Yes ❑ No Type:
____

COMPLETED BY:
____

REVIEW OF SYSTEMS

Please check if any of the following apply to you currently or in the past 4 weeks:

Gynecology
- □ Heavy periods
- □ Severe cramps
- □ Painful intercourse
- □ Abnormal pap smears
- □ History of genital warts
- □ History of herpes
- □ History of chlamydia
- □ History of gonorrhea
- □ History of Syphilis
- □ Other STDs
- □ Frequent vaginal infections

Breasts
- □ Lumps
- □ Pain
- □ Discharge
- □ Self-exams

General
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills

Skin
- □ Rashes
- □ Lumps
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair and nail changes

Head
- □ Headache
- □ Head injury

Ears, Nose Mouth
- □ Decreased hearing
- □ Earache
- □ Sinus problems
- □ Non-healing sores
- □ Sore throat
- □ Dry mouth

Eyes
- □ Vision Loss/Changes
- □ Glasses or contacts
- □ Glaucoma
- □ Cataracts

Respiratory
- □ Cough
- □ Coughing up blood
- □ Shortness of breath
- □ Wheezing

Cardiovascular
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty breathing lying down
- □ Swelling

Gastrointestinal
- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea

Urinary
- □ Frequency
- □ Urgency
- □ Burning or pain
- □ Blood in urine
- □ Incontinence

Vascular
- □ Calf pain with walking
- □ Leg cramping

Musculoskeletal
- □ Muscle or joint pain
- □ Back pain
- □ Redness of joints
- □ Swelling of joints
- □ Neck Pain

Neurologic
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Weakness
- □ Numbness
- □ Tingling
- □ Tremor

Hematologic
- □ Easy bruising
- □ Easy bleeding

Endocrine
- □ Diabetes
- □ Thyroid problems
- □ Head or cold intolerance
- □ Sweating
- □ Frequent urination
- □ Thirst
- □ Change in appetite

Psychiatric
□ Anxiety
□ Depression
□ Memory loss