WOMAN'S HEALTH GROUP

Chundar Tsai, MD, PhD

GYNECOLOGY CONSULTATION

The information provided will become part of your medical record and is totally **confidential.** This information will assist us in our effort to provide quality health care.
Name: _____ DOB:_____ Date:_____
Please note the reason for your visit today:
_____

ALLERGIES:
Please note any allergies or reactions to medications or other agents. ☐ None
Medication: _____ Reaction:_____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

CURRENT PRESCRIPTION MEDICATIONS:
Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS.
☐ **None**
Med/Dose/Instr:
_____
Med/Dose/Instr:
_____
Med/Dose/Instr:
_____
Please list any non-prescription medications, supplements and/or herbal remedies you take:
_____

GYNECOLOGIC STATUS
Menstrual History: (skip to next section if you are Post-Menopausal)
Date your last period began: _____ Was it normal? ☐ no ☐ yes
How often are your periods? _____ How many days do your periods last?_____
Flow: ☐ heavy ☐ average ☐ light How old were you when your periods started:_____
Do you think you have a problem with your period? ☐ no ☐ yes
Date of last pap smear: _____ Last mammogram:_____
Last DEXA:_____ Last Colonoscopy:_____
Any history of abnormal pap? _____ Any history of abnormal mammo:_____
If you are 26 years old or younger, have you received the HPV vaccine? ❒Yes ❒ No
Birth control:
What method of birth control, if any are you using? _____
Post-Menopausal: (skip if your are pre-menopausal)
Post Menopausal since age: _____ Have you ever been on Hormone Replacement Therapy? ☐ no ☐ yes
Are you experiencing any post-menopausal bleeding? ☐ no ☐ yes
Sexual History:
Are you sexually active? ☐ no ☐ yes Are your partner(s) ☐ male ☐ female
Do you or your partner have more than one partner? ☐ no ☐ yes ☐ I don't know

PAST MEDICAL HISTORY
GYNECOLOGIC HISTORY:
Check if you have had any of the following:
☐ ovarian cyst ☐ fibroid uterus ☐ infertility
☐ polycystic ovaries ☐ endometriosis
☐ abnormal uterine structure ☐ abnormal pap
OBSTETRICAL HISTORY
How many times have you been pregnant? _____ How many children do you have? _____
How many were delivered vaginally? _____ C-Section: _____Full Term:_____
Pre-Term: _____Miscarriage: _____Terminated:_____

Continue on back →

MEDICAL HISTORY:

Do you have any major medical problems or on going diagnosis? ☐ no ☐ yes:

_____

Have you ever had or been diagnosed with:

☐ cancer	☐ gallbladder disease	☐ migraines
☐ heart murmur	☐ hepatitis/jaundice	☐ depression
☐ high blood pressure	☐ irritable bowel	☐ alcoholism
☐ high cholesterol	☐ colitis	☐ drug addiction
☐ heart attack or angina	☐ thyroid disease	☐ osteoporosis
☐ stroke	☐ diabetes	☐ arthritis
☐ phlebitis/blood clots	☐ anemia	☐ kidney problems
☐ pulmonary embolus	☐ sickle cell trait	☐ Other _____
☐ asthma	☐ TB (tuberculosis)	
☐ ulcers	☐ seizures	

SURGICAL/HOSPITALIZATION HISTORY

List all hospitalization, operations or major injuries including month/year (including c-sections):

_____

_____

SOCIAL HISTORY

Do you smoke cigarettes?	☐ never ☐ formerly ☐ currently If currently, Amount/PPD: _____
Do you consume alcohol?	☐ no ☐ yes
Exercise regularly?	☐ no ☐ yes
Do you consume caffeine?	☐ no ☐ yes ☐ soda ☐ coffee ☐ tea
Any recreational drug use?	☐ no ☐ yes
Special diet?	☐ no ☐ yes ☐ _____

Have you recently experienced any of the following in the past 7 days? ***(Check ALL that apply)***

General
- ❒Fatigue
- ❒Chills
- ❒Fever
- ❒Change in appetite
- ❒Insomnia

Eyes, Ears, Nose and Throat
- ❒Visual changes
- ❒Hearing loss
- ❒Sore throat
- ❒Nasal Congestion
- ❒Runny Nose
- ❒Ear Pain

Respiratory
- ❒Shortness of breath
- ❒Cough
- ❒Wheezing or Asthma

Cardiovascular
- ❒Chest pain
- ❒Palpitations
- ❒Childhood heart disease
- ❒Cold Extremities

Gastrointestinal
- ❒Abdominal pain
- ❒Bloating
- ❒Blood in stool
- ❒Diarrhea
- ❒Constipation
- ❒Hemorrhoids
- ❒Nausea/Vomiting

Urinary
- ❒Pain with urination
- ❒Blood in urine
- ❒Frequent urination
- ❒History of frequent infections
- ❒Urinary incontinence

Skin
- ❒Rashes
- ❒Bruising
- ❒Moles changing

Breast
- ❒Lumps
- ❒Discomfort
- ❒Nipple discharge
- ❒Skin changes

Neurologic
- ❒Dizziness
- ❒Balance difficulty
- ❒Headaches
- ❒Numbness
- ❒Tingling
- ❒Difficulty walking

Psychiatric
- ❒Anxiety
- ❒Depression
- ❒Suicidal thoughts
- ❒Insomnia
- ❒Severe mood swings

Endocrine
- ❒Increased thirst
- ❒Increased urination
- ❒Hot flashes
- ❒Intolerance to heat
- ❒Intolerance to cold

Other Concerns: