GORDON C GUNN, MD, FACOG
CONCIERGE PERSONALIZED CARE
GYNECOLOGY • HORMONE THERAPY
INTEGRATIVE MEDICINE

MEDICAL HISTORY - FEMALE

Legal Name: ______________________________________ **DOB:** ____________ **Date:** ______________

Marital Status: M S D W **Name of Primary Care Physician:** ______________________________

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: ____

____

____

Menstrual History:

- Are you having regular menstrual periods? ☐Y ☐N If No, how frequent: ___________________
- **Date of your last menstrual period:** _______________
- Has there been any recent change in your periods? ☐N ☐Y If Yes, describe: ______________________
- Do you experience pain with your periods? ☐N ☐Y If Yes, severity (scale 1-10): ___________

Pelvic symptoms: Do you have <u>any</u> of the following?

- Pelvic pressure, low back pain, sensation of your organs falling out? ☐N ☐Y
- Do you have episodes of pelvic pain? ☐N ☐Y If yes, severity (scale 1-10): ____
- PMS (i.e. irritability, weight gain, anxiety, bloating, mood swings? ☐N ☐Y
- Questions regarding your sexual response? ☐N ☐Y
- Number of lifetime sexual partners? __________

Menopause:

- Do you have any menopausal symptoms (hot flashes, night sweats)? ☐N ☐Y If yes, how often? _____________

Current Method of Contraception (including vasectomy): ____

Date of <u>Last</u> Pap Smear: ___________________ **History of abnormal Pap?** ☐N ☐Y If yes, when? _________________

REVIEW OF SYMPTOMS

Are you <u>CURRENTLY</u> experiencing <u>any</u> of the following symptoms? If YES, Please Describe:

- **General:** headaches, sleep problems, unusual fatigue? ☐N ☐Y ______________________________
- **Eyes:** double vision, glaucoma, dryness? ☐N ☐Y ______________________________
- **Ears, Nose, or Throat:** sinus problems, difficulty swallowing? ☐N ☐Y ______________________________
- **Cardiovascular:** chest discomfort, unusual heart beat, mitral valve prolapse, high blood pressure, leg swelling, shortness of breath, dizzy spells? ☐N ☐Y ______________________________
- **Respiration:** asthma, chronic cough, difficulty breathing? ☐N ☐Y ______________________________
- **Breasts:** cysts, nodules, pain? ☐N ☐Y ______________________________
- **Skin:** acne, moles, cancer? ☐N ☐Y ______________________________
- **G-I:** abdominal pain, bloating, diarrhea, constipation, liver disease, rectal bleeding, stool leakage? ☐N ☐Y ______________________________
- **Urinary:**
  - Recent kidney or bladder infection? ☐N ☐Y
  - Loss of urine when coughing, sneezing, or exercising? ☐N ☐Y
  - Able to go for more than 3 hours without urination? ☐N ☐Y **If No**, How long? Every ______ hrs.
  - Wear a pad for "just in case" protection? ☐N ☐Y
  - Regularly get up at night to urinate? ☐N ☐Y **If Yes**, Number of times ______
- **Endocrine:** excessive thirst, chronic fatigue, too hot/cold? ☐N ☐Y ______________________________
- **Hematologic/Lymphatic:** anemia, swollen glands? ☐N ☐Y ______________________________
- **Musculo-Skeletal:** neck, back or joint pain, muscle pain? ☐N ☐Y ______________________________
- **Neurologic:** numbness, seizures, history of stroke or TIA? ☐N ☐Y ______________________________
- **Psychiatric:** anxiety, depression, loneliness ? ☐N ☐Y ______________________________

PERSONAL, FAMILY AND SOCIAL HISTORY

Personal History:

- **Obstetrical History:**
  # of Pregnancies:_____ # of Vaginal Deliveries:_____ # of C-Sections:______ # of Miscarriages: _____
- **Serious Illnesses or Injuries:** (Please list}
  ____ ____
  ____ ____
- **Major Operations:** (Please list & indicate year of each surgery)
  ____ ____
  ____ ____
- **Family History:** Do **any** of your family members have a history of: Heart Disease; Stroke; Sudden Death; Diabetes; Cancer; Endometriosis; Osteoporosis, Alzheimer's or Dementia? **If yes**, please **List** and note age.
  - Father: ______________________________
  - Mother: ______________________________
  - Brother(s): ______________________________
  - Sister(s): ______________________________
  - Maternal Aunt(s): ______________________________
  - Maternal Grandmother: ______________________________
  - Maternal Grandfather: ______________________________
- **Social History:**
  - Do you smoke? ☐N ☐Y If yes, number of packs/day? _______ How many years? _________
  - Do you drink alcohol? ☐N ☐Y If yes, more than 2 drinks/day? ☐N ☐Y If yes, amount? _________
  - Do you exercise regularly? ☐N ☐Y Describe activity: ______________________________
  - How many hours do you normally sleep at night? __________ Hrs.
  - What is your occupation? ______________________________
  - What are your hobbies? ______________________________
  - What is your stress level? ☐ None ☐ Low ☐ Moderate ☐ High
  - Do you meditate? ☐N ☐Y If yes, how often? ______________________________

HEALTH SCREENING STUDIES

Have you had any of the following? If yes, indicate most recent year			**YEAR**	
♦ Mammogram	☐N	☐Y	___________	
♦ Bone Density (DXA Scan) for Osteoporosis	☐N	☐Y	___________	
♦ Colonoscopy	☐N	☐Y	___________	
♦ Immunizations:				
• Hepatitis A/B	☐N	☐Y	___________	
• Tetanus (within last 10 years?)	☐N	☐Y	___________	
• Shingles (Age 60 or over)	☐N	☐Y	___________	
• Pneumonia (Age 65 or over)	☐N	☐Y	___________	
♦ Cardio-Vascular Testing:				
• EKG (Electrocardiogram)	☐N	☐Y	___________	
• Carotid Artery Ultrasound (Stroke Risk)	☐N	☐Y	___________	
• Echo Cardiogram of Heart	☐N	☐Y	___________	
• Stress Test	☐N	☐Y	___________	
♦ Hereditary Cancer Screening:	☐N	☐Y	___________	Result? _________

PHARMACY Name: __________________ **Address:** ______________________________

Phone: ______________________ **FAX:** ______________________

Provider's Signature: ______________________ **Date:** _________ **Revised: 08.20.2018**