Pouru Bhiwandi, MD

GYN Center for Women, PA, 3100 Duraleigh Road, Suite 307, Raleigh, NC 27612

Date ___/___/____

Patient Name ____________________________ DOB _____/_____/_____ Reason for your visit__ ______________________

Are you having any gynecological problems? ____

Past Surgical History

Surgical Procedure	Reason	Approximate Year /Date		Surgical Procedure	Reason	Approximate Year /Date

Medications

Medication	Dosage	Frequency	When Taken		Medication	Dosage	Frequency	When Taken

ALLERGIES / ALLERGIC REACTIONS TO MEDICATIONS **LATEX ALLERGY ?** **DESCRIBE**______________________________

Drug / Substance	Reaction	Severity

YOUR PERSONAL MEDICAL HISTORY AND YOUR IMMEDIATE FAMILY MEMBER'S MEDICAL HISTORIES **_Were you adopted? YES NO**

ease mark with an X for yourself or an immediate blood family member who has a medical history of any of the following health issues. Leave blank if non

Medical Condition	ME	My Family	Who? Ex: Mat GM		Medical Condition	ME	My Family	Who? Ex: Mat GM
Cancer BRCA- Tested					DVT or Pulmonary Embolism			
Cancer Breast					Usual Childhood Chicken Pox			
Cancer Cervical					Shingles			
Cancer Colon					HIV			
Cancer Endometrial					Rheumatic Fever			
Cancer Lung					Tuberculosis / Positive PPD			
Cancer Other					Headaches/ Migraines			
Cancer Ovary					Memory Loss/ Dementia			
Cancer Skin					Seizures / Epilepsy			
Cancer Vaginal or Vulvar					Stroke / TIA			
Cardiac Aneurysm					Ortho-Chronic Back Pain			
Cardiac Atrial Fib/ flutter/arrhythmia					Other-Degenerative Joint Disease			
Cardiac –HEART . Disease Cardiac - Heart AttacK					Ortho-Fractures / Other			
High Blood Pressure					Psychological cond. – ADD			
High Cholesterol					Anxiety Disorder			
Mitral Valve Prolapse/ Requiring Prophylactic medicine?					Bipolar Disease			
Dermatology Acne					Depression			
Dermatology-Eczema/ Psoriasis					Eating Disorder			
Dermatology-Other					PMS / PMDD			
ENT-Hearing Loss					Asthma			
Diabetes Type 1 Type 2					COPD / Emphysema			
Personal HX of Gestational Diabetes					Seasonal Allergies / Rhinitis			
Elevated Prolactin					Sleep Apnea			
Osteopenia Osteoporosis					Arthritis: Rheumatoid?____ Osteo?			
Thyroid Disorder Hypo? Hyper?					Autoimmune Disease			
Eyes-Vision loss/ Macular Degeneration					Fibromyalgia/ Chronic Pain			
Colon Polyps					Restless Leg Syndrome			
Crohn's/ Ulcerative Colitis					Frequent Urinary Tract Inf.			
Gallbladder Disease (gallstones)					Hematuria-Blood in Urine			
Hemorrhoids					Interstitial Cystitis			
Irritable Bowel Syndrome					Kidney Disease			
Liver Disease/ Hepatitis					Kidney Infection			
Reflux Stomach ulcers					STD / Sexually Transmitted Diseases			
Vitamin Deficiency					Urinary Incontinence			
Anemia					Weight Management Issues			

Please read all lines fully left to right, answer all questions **SOCIAL HISTORY** NAME________________________ DATE___/___/

If you answered yes to depression above, do you currently ever have thoughts of harming yourself? YES NO

SMOKER? NEVER CURRENT	YES #/DAY____# PKS / WK____	FORMER? NO YES # OF YEARS?___	WHEN DID YOU QUIT?______
ALCOHOL INTAKE? CIRCLE ONE	NONE OCCASSIONAL MODERATE	HEAVY # Drinks /week ________	# days this year you binge drank_
Do you leak urine when you? CIRCLE	COUGH SNEEZE LAUGH RUN	CAN'T GET TO BATHROOM IN TIME? Yes	CIRCLE Rarely Often Constant
EXERCISE? CIRCLE ONE	OCCASSIONAL	MODERATE	HEAVY
SPECIAL DIET? NO YES	IF YES WHAT?		
CAFFIENE INTAKE?	CIRCLE ONE NONE	OCCASSIONAL MODERATE	HEAVY #_______PER DAY
ILLICIT DRUGS? WHAT?	__________ YRS OF USE _____	FREQUENCY? OCCASSIONAL	MODERATE HEAVY
COUNTRY OF YOUR BIRTH?		PASSIVE SMOKE EXPOSURE? CIRCLE	NO YES LT MOD HEA
ETHNIC BACKGROUND CIRCLE	CAUCASION AFRICAN AMER.	LATIN NATIVE AMER ASIAN JEWISH	OTHER?

EDUCATION LEVEL? HS GRAD COLLEGE GRAD POSTGRAD Ph.D / OCCUPATION (Job)?

MARITAL STATUS? CIRCLE | MARRIED SINGLE DIVORCED SEPERATED WIDOWED DOMESTIC PARTNER / Heterosexual Homosexual Bi-Sexual

RELIGION PREFERENCE? | / SEXUALLY ACTIVE NOW? YES NO CURRENT # OF SEX PARTNERS? ___

SPOUSE / PARTNER'S FIRST NAME? __________ | PROTECTED SEX? ALWAYS | USUALLY NO

HISTORY OF DOMESTIC VIOLENCE? YES NO | CURRENTLY EMPLOYED? YES NO | YOUR STRESS LEVEL? LOW MOD HI

OCCUPATIONAL HEALTH RISKS? NO YES DESCRIBE?

IN AN EMERGENCY WOULD A BLOOD TRANSFUSION BE ACCEPTABLE TO SAVE YOUR LIFE? YES NO COMMENT?

DO YOU PERFORM A MONTHLY SELF BREAST EXAMINATION? NO YES / HOBBIES / ACTIVITIES? ____________ ____________

DO YOU REGULARLY USE SEAT BELTS? YES NO / HAVE YOU TRAVELED TO A ZIKA VIRUS INFECTED AREA RECENTLY? NO YES WHEN?

DO YOU HAVE ANY ZIKA VIRUS SYMPTOMS? NO YES CIRCLE FEVER RASH JOINT PAIN CONJUNCTIVITIS (PINK EYE)

GYN HISTORY

DATE OF YOUR LAST MAMMOGRAM?	DATE OF LAST COLONOSCOPY? Year? / Age?
DATE OF BONE MINERAL DENSITY STUDY DEXA?	DATE OF LAST PELVIC ULTRASOUND?
DATE OF LAST PAP SMEAR? EVER HAD ABNORMAL PAP? *NO YES*	HPV TEST HISTORY? *POSITIVE NEGATIVE* / HPV VACCINATED? *YES N*
PERSONAL HISTORY OF CERVICAL DYSPLASIA? (PRE-CANCER) *YES NO*	PERSONAL HISTORY OF COLPOSCOPY? *YES NO* CRYOSURGERY? *YES N*

PERSONAL HISTORY OF CANCER OF THE CERVIX? *NO YES* TREATMENT DONE? | *LEEP* | *CERVICAL CONE* | *HYSTERECTOMY*

AGE YOU WERE WHEN YOU 1ST HAD SEXUAL INTERCOURSE? | TOTAL NUMBER OF LIFETIME PARTNERS? (THIS ASSESSES YOUR R

SEXUAL ORIENTATION? CIRCLE | ***HETEROSEXUAL*** | ***HOMOSEXUAL*** | ***BISEXUAL***

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? *NO YES* | DESCRIBE?

BIRTH CONTROL

PLEASE CIRCLE YOUR CURRENT BIRTH CONTOL METHOD? | *ABSTINENCE* | *CONDOMS* | *DEPO PROVERA* | *DIAPHRAGM* | *ESSURE* | *C*

ORAL CONTRACEPTIVE PILLS	*RHYTHM*	*RING*	*IUD Type?*	*TUBAL LIGATION*	*PARTNER VASECTOMY*	*MENOPAUSE*	*HYSTERECTOMY*	*NONE*	*INFERTILITY*

MENSTRUAL HISTORY

AGE YOU WERE WITH 1ST MENSTRUATION / PERIOD? | 1ST DAY OF YOUR MOST RECENT PERIOD? / /

WAS THIS LAST PERIOD REGULAR? ***YES NO*** DESCRIBE?

FREQUENCY OF CYCLE? CIRCLE ***MONTHLY EVERY 28 DAYS*** ***LESS THAN 3 WEEKS 1ST DAY TO 1ST DAY*** ***MORE THAN 35 DAYS*** ***VERY IRREGULAR***

FLOW OF PERIOD? CIRCLE *LIGHT MODERATE HEAVY VERY HEAVY W/ CLOTS*

HOW MANY DAYS DO YOU FLOW? IF HEAVY, HOW MANY DAYS IS IT HEAVY?

DO YOU BLEED BETWEEN PERIODS? *YES NO* | DO YOU HAVE PAIN / CRAMPS? *YES NO* | IF YES, DOES ANYTHING RELIEVE THEM?

HAVE YOU REACHED MENOPAUSE? (1 yr w/o period) *YES NO* | WHAT YEAR? | HOW OLD WERE YOU?

HAVE YOU HAD ANY EPIDODES OF POST MENOPAUSAL BLEEDING SINCE THEN? *NO YES* DESCRIBE?

POST MENOPAUSAL HORMONE USE? CIRCLE *NEVER CURRENT USER* ***PAST USER?*** *YES HOW LONG DID YOU USE?*

ANY HISTORY OF ENDOMETRIOSIS? *YES NO*	ANY HISTORY OF UTERINE FIBROIDS? *YES NO*
ANY HISTORY OF INFERTILITY? *YES NO*	DID YOU TAKE HORMONES FOR INFERTILITY? *YES NO*
ANY HISTORY OF OVARIAN PROBLEMS? *YES NO*	ANY HISTORY OF PCOS (POLYCYSTIC OVARIES)? *YES NO*

OBSTETRIC HISTORY

AGE AT 1ST PREGNANCY? | AGE AT LAST PREGNANCY?

TOTAL # OF PREGNANCIES	# THAT WERE FULL TERM	# THAT WERE PRE-MATURE	# OF ABORTIONS?	# OF SPONTANEOUS MISCARRIAGES?
# OF LIVE BIRTHS	# OF VAGINAL DELIVERIES?	# OF C-SECTIONS?	ANY MULTIPLES?	ANY COMPLICATIONS?

HILDREN'S NAMES & YEAR BORN ____