

MEDICAL HISTORY
(PLEASE PRINT)



Please Check Your Physician:

- Theresa M. Patton, MD
- Kecia L. Foxworth, MD
- Diane K. Huynh, DO
- Angelica Knickerbocker, MD
- Leslie Johnson, MD

Name _____ Date of Birth _____ Age _____

PATIENT INFORMATION

Preferred Pronouns she/her he/him they/them she/they he/they other _____

Sex at birth female male intersex decline to state

Gender Identity female transfemale male transmale gender queer/non-conforming other _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? – check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Well woman annual gyn care | <input type="checkbox"/> Vulvar pain/itching | <input type="checkbox"/> Surgery consult |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Second opinion |
| <input type="checkbox"/> Birth control options | <input type="checkbox"/> Fibroid management | <input type="checkbox"/> Abnormal pap |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Menopause symptoms | |
| <input type="checkbox"/> Vaginal discharge/odor | <input type="checkbox"/> Other _____ | |

If you have symptoms, please describe for how long, what treatments you have tried and any other important details:

Did someone refer you to Kessler? If so, who? _____

MEDICAL HISTORY

Check all that apply and add the name of the condition if known

- High blood pressure
- High cholesterol
- Cardiovascular disease (heart attack, stroke, etc) _____
- Blood clotting disorder _____
- Auto-immune disease (Lupus, Sjogren, etc) _____
- Psychiatric diagnosis (Anxiety, Depression, Bipolar, etc) _____
- Migraines
- Seizures
- Diabetes (Type) _____
- Thyroid disorder _____
- GERD/ acid reflux
- Bowel/GI disease _____
- Cancer (which?) _____
- Other _____

FAMILY HISTORY

Do you have a family history of:	Yes (Y) or No (N)?	Which Relative?	Maternal (M) or Paternal (P) side of the family?	Age at Diagnosis?
Breast cancer at 49 or younger?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Two breast cancers (bilateral) in one relative at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Three breast cancers in relatives on same side of family at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Ovarian cancer at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Pancreatic cancer at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Male breast cancer at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Metastatic prostate cancer at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Colon cancer at 49 or younger? (1 st degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Uterine cancer at 49 or younger? (1 st degree relative)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
Ashkenazi Jewish ancestry w/ breast cancer at any age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> P	
If you have family history of <u>other</u> cancers, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who?	What genes?	What was the result?
Do you have a family history in 1st degree relative of the following?				
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who?		
Cardiovascular disease (heart attack, stroke, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who?		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who?		

OBSTETRIC HISTORY

If never pregnant, write 0 next to Total Pregnancies and skip to Menstrual History

Total Pregnancies	_____	Miscariages	_____
Term births (37 weeks+)	_____	Abortions	_____
Preterm births (<37 weeks)	_____	Ectopic/Tubal pregnancies	_____
Multiple births (twins, etc)	_____	Molar pregnancies	_____
Living children	_____		

DATE	WEEKS PREGNANT	LENGTH OF LABOR	BIRTH WEIGHT	SEX	DELIVERY TYPE	EPIDURAL (Y/N)	COMPLICATIONS	LOCATION
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		
						<input type="checkbox"/> Y <input type="checkbox"/> N		

MENSTRUAL HISTORY

At what age did you have your first period? _____

**If you still have menstrual cycles (periods), please answer the following
(please answer these even if not having cycles due to contraception):**

When was the first date of your last period? _____

Do you have regular predictable periods every month? Y N

How many days do you typically bleed? _____

Do you bleed or spot between periods? Y N

Do you have any bleeding after sex? Y N

Describe your flow light moderate heavy

Is your period painful? Y N

If you do NOT have menstrual cycles, please answer the following:

Age at last period: _____

What is the reason? menopause hysterectomy ablation unknown other _____

SEXUAL HISTORY

Currently sexually active? Y N

Are you trying to become pregnant? Y N

Current birth control method (*check all that apply*)

None Condoms Other barrier _____ Birth control pills _____ Patch

Nuvaring Depo-Provera Nexplanon Hormonal IUD _____ Copper IUD

Tubal/salpingectomy Vasectomy Essure Rhythm/natural family planning

Number of lifetime sexual partners: _____

Number of new partners in last year: _____

Who do you have sex with? (*check all that apply*) Men Women Other

Have you ever had any of the following infections? (*check all that apply*)

Genital Warts Syphilis Hepatitis B Hepatitis C HIV/AIDS

Chlamydia Gonorrhea Trichomonas Pelvic Inflammatory Disease (PID)

Tubo-Ovarian Abscess (TOA) Genital Herpes

Do you have pain during intercourse? Y N

Do you have any questions about sex, such as pain or decreased desire? Y N

SOCIAL HISTORY

Occupation _____

Marital status _____

Have you ever been hit, slapped, kicked or physically hurt by someone? Y N

Are you in a relationship with someone who threatens or hurts you? Y N

Has anyone forced you to have sexual activities that made you uncomfortable? Y N

Do you smoke cigarettes or use tobacco? Y, currently Y, but quit N, never

If yes, how many per day? _____ How many years have you smoked? _____

Do you want help quitting? Y N

Do you drink alcohol? Y N If yes, number of drinks per week _____

Have you ever felt the need to cut down on drinking? Y N

Have you ever felt annoyed by criticism of your drinking? Y N

Have you ever had guilty feelings about your drinking? Y N

Do you ever take a morning eye opener (a drink first thing in the morning to steady your nerves or get rid of a hangover)? Y N

Do you use any of the following? (*check all that apply*)

marijuana cocaine heroin LSD mushrooms ecstasy other uppers other downers

vaping none

Do you use needles for any reason? Y N If yes, why? _____