Emerson GYN Surgical Associates
Megan Loring, MD
Health History

NAME: ____________________ **DATE:** ____________________

AGE: __________ **DATE OF BIRTH:** ______________ **HEIGHT:** ____________ **WEIGHT:** ____________

REFERRING PHYSICIAN: ____________________ **PRIMARY CARE PHYCISIAN:** ____________________

PHARMACY NAME/TOWN: ____________________ **MAIL ORDER PHARMACY:** ____________________

CHIEF COMPLAINT (Reason for your visit today): ____________________

ALLERGIES (Please include: Medications, Latex, IV Contrast, Shellfish, and Foods):

SUBSTANCE: **REACTION**: (ie: Rash, Nausea, Difficulty Breathing, etc.)

MEDICATIONS (Please list all that you are currently taking; including all Vitamins, Supplements, and Aspirin):

NAME/ DOSAGE/ FREQUENCY **NAME/ DOSAGE/ FREQUENCY**

PAST/ CURRENT MEDICAL PROBLEMS (Please indicate the approximate date of your diagnosis):

PREVIOUS SURGERIES: (Date and Type)

OBSTETRIC/GYNECOLOGIC HISTORY (Please list approximate dates of pregnancies and their outcome (delivery, miscarriage, etc)

LMP____________ **HOW FAR APART ARE YOUR PERIODS? (days)**__________ **AMOUNT OF FLOW?: light - mod - heavy**
AGE OF FIRST MENSES__________ **PAIN WITH PERIODS?**__________ **HOW LONG DOES PERIOD LAST?**__________
AGE OF MENOPAUSE __________ **ANY USE OF HORMONE REPLACEMENT**?__________
CURRENTLY SEXUALLY ACTIVE?__________ **WITH: men - women - both?**
CURRENT CONTRACEPTION __________ **ANY PROBLEMS WITH SEX?**__________

HEALTH SCREENING:

LAST PAP: ___________________ HPV DONE? (y/n)____________ HISTORY ABNORMAL PAP?_________________________
LAST MAMMOGRAM: _________________________ LAST BONE DENSITY? _________________________
LAST COLONOSCOPY: _________________________

FAMILY HISTORY: (Fill in any that pertain to an immediate relative(s) (ie: Parents; Grandparents; Aunts; Uncles; Siblings) Please indicate the age of diagnosis, if known.

Breast Cancer: ___________________________________ Ovarian Cancer:____

Endometrial Cancer: ______________________________ Colon Cancer: ____

Osteoporosis: ___________________________________ Heart Disease: ____

Diabetes: _______________________________________ Other: ____

SOCIAL HISTORY:

Marital Status: Single / Married / Divorced / Widowed / Separated
Alcohol Use (What Type/ Amount/ How Often?): ____
Tobacco Use: Never
Quit ___________ (Year) How Much (Packs Daily)? ____________ How Long? _______________________
Current - How Much (Daily)? _____________________________ How Long? _______________________
Drug Use: Yes / No If yes, what type(s) and how often do you use?: ____
Occupation: ____

REVIEW OF SYSTEMS: Have you commonly or recently had any of these symptoms? Please circle all applicable.

Constitutional: Fever / Chills / Dizziness / Night Sweats

Eyes: Double Vision / Other : ____

Ears/ Nose/ Mouth/ Throat: Pain / Pressure / Deafness / Hoarseness

Cardiovascular: Chest Pain / Chest Pressure / Irregular Heart Beat / Shortness of breath / Palpitations

Respiratory: Chronic Cough / Shortness of breath / Sleep Apnea

Gastrointestinal: Abdominal Pain / Vomiting / Heartburn / Change in Bowel Habits / Bloody Stools / Loss of Appetite / Crohn's

Genitourinary: Urinary Tract Infections / Kidney Stones / Waking up at night to urinate / Pain or difficulty urinating

Musculoskeletal: Joint Pain / Swelling / Weakness / Stiffness / Back Pain

Neurological: Weakness / Numbness / Speech Problems / Memory Problems / Headaches

Psychiatric: Depression / Anxiety / Panic Attacks / Insomnia

SIGNATURE: ____ **Date**: _______________________