CENTER FOR SPECIAL MINIMALLY INVASIVE SURGERY
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PATIENT HISTORY FORM

Today's Date _____

** Please complete this form as accurately as possible. Please print

Name: _____ Age: _____

Date of birth: _____/_____/_____ Marital Status: S M D W

Email address: _____

Address: _____ City: _____ ST:____ Zip: _____

Home phone: ( ) _____ Wk ( ) _____ Cell ( ) _____

Social Security Number: _____ - _____ - _____

Person to notify in case of emergency: _____ Relationship: _____

Contact phone number: ( ) _____

Primary Care Physician: _____ Phone ( ) _____

Internal Medicine: _____ Phone ( ) _____

CHIEF COMPLAINT

Reason for today's visit: _____

_____

HISTORY OF PRESENT ILLNESS

Severity: mild/moderate/severe/other _____ (circle one)
Duration: < 6 months / > than 6 months / other _____
Timing: cyclic / acyclic / intermittent / other _____
Associated Symptoms: bladder / bowel / other _____

REVIEW OF SYSTEMS

GENERAL HEALTH

☐ Unexplained and sudden weight loss or gain
☐ Fever
☐ Fatigue
☐ Hot flashes/night sweats
☐ Shortness of breath
☐ Palpitations
☐ Chest pain
☐ Depression/Crying
☐ Anxiety
☐ Insomnia
☐ Other

URINARY HEALTH

☐ Painful urination
☐ Blood in urine
☐ Urgency (desire to use bathroom immediately)
☐ Frequency (desire to use bathroom too frequently)
☐ Incontinence If yes, do you notice it when you cough / sneeze / laugh **Y** **N**
☐ History of frequent urinary tract infections?
☐ How many times during the day do you go to the bathroom? ☐ 3-6 ☐ 7-10 ☐ 11-14 (more)
☐ How many times a night do you go to the bathroom? ☐ 0 ☐ 1 ☐ 2 ☐ 3
If you get up at night, to what extent does it bother you?
☐ None ☐ Mild ☐ Moderate ☐ Severe
☐ Do you still have urgency after you urinate? **Y** **N**
☐ How often does your urgency bother you? ☐ Never ☐ Occasionally ☐ Usually ☐ Always

GYNECOLOGICAL HEALTH

Last menstrual period: _____/_____/_____
* Do you spot between your periods? **Y** **N**
* What age were you when you started menstruating? _____

Menstruation occurs every _____ days and lasts for _____days.
☐ Regular
☐ Irregular
☐ On continuous birth control (acyclic – stops periods)
☐ Painful periods/heavy bleeding/clotting/unexplained absence of periods (Circle all that apply)

Last PAP smear _____/_____/_____ Results _____
* Do you have history of abnormal pap? **Y** **N** Result/Treatment _____

Last Mammogram _____/_____/_____ Results _____
* Do you have history of abnormal mammogram? **Y** **N** Results/Treatment _____
* Do you perform your own self breast exams every month? **Y** **N**

Have you ever had an endometrial biopsy done? **Y** **N** If so, when/results _____

Patient Name _____

Have you ever had a colorectal screening? **Y N** If so, when/results _____

- ☐ Are you currently sexually active? **Y N**
- ☐ How old were you at the time of FIRST intercourse _____
- ☐ How many sexual partners do you currently have? _____
- ☐ Are you able to have an orgasm? **Y N**
- ☐ Are you able to become sexually aroused? **Y N**
- ☐ If you are sexually active, do you have pain or urgency to urinate during or after inter-Course? ☐ Never ☐ Occasionally ☐ Usually ☐ Always
- ☐ Have you ever had :
  - ☐ Chlamydia When? _____
  - ☐ Herpes When? _____
  - ☐ Gonorrhea When? _____
  - ☐ Condyloma (warts) When? _____
  - ☐ Exposure to HIV? When? _____
- ☐ Have you had the Gardasil Injection? **Y N**
- ☐ Do you consider yourself to be heterosexual/bisexual/homosexual (circle all that apply)
- ☐ Current birth control method _____
- ☐ Have you ever been the victim of sexual abuse? **Y N**

_____

GASTROINTESTINAL HEALTH

- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea and vomiting
- ☐ Painful bowel movements
- ☐ Irritable bowel syndrome

HEMATOLOGY/LYMPH SYSTEM

- ☐ Bruise easily
- ☐ Bleeding problems (i.e. cuts that take a long time to stop bleeding)
- ☐ Large lymph nodes

ALLERGIES

- ☐ None
- ☐ Drug _____ Reaction _____
- ☐ Drug _____ Reaction _____
- ☐ Drug _____ Reaction _____
- ☐ Do you suffer from seasonal allergies? **Y N** Worse during summer/fall/winter/spring

MEDICATIONS

- ☐ None
- ☐ Drug/dosage _____
- ☐ Drug/dosage _____
- ☐ Drug/dosage _____

PAST MEDICAL HISTORY **Check all that apply past OR present**

( ) High blood pressure
( ) Diabetes Type I or II
( ) Heart murmur
* Do you have mitral valve prolapse? **Y N**
If so, do you require antibiotics? **Y N**
( ) Heart Attack
( ) Rheumatic fever
( ) Asthma
( ) Other _____

( ) Pneumonia
( ) Tuberculosis
( ) Hepatitis Type _____
( ) Phlebitis (blood clot)
( ) Pulmonary Embolus (clot in lungs)
( ) Thyroid disease
( ) Stroke
( ) Irritable bowel syndrome

SURGICAL HISTORY

Please list all in and out patient surgical procedures and their dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you ever had a problem with general anesthesia? **Y N** If yes, describe _____

_____

Have you ever been hospitalized other than surgery? If yes, explain _____

SOCIAL HISTORY

Occupation _____
Do you smoke? **Y N** If yes, how many packs per day _____
Are you currently or have you ever used recreational drugs? **Y N**
If yes…Type _____ When did you stop? _____
Do you drink alcohol? **Y N** If yes, how many per week? _____
Have you ever been or are you currently a victim of domestic violence? **Y N**
Have you ever been sexually assaulted? If yes, when _____

- Was this reported to authorities? _____

FAMILY HISTORY **List all serious illness and age of onset. State age and cause of death if applicable**

Mother: _____
Father: _____
Brothers: _____
Sisters: _____

Patient Name _____

Has anyone in your family had breast cancer? **Y N** If yes, who? _____ Age? _____
History of other family cancer? **Y N** If yes, who and type _____
If you are African American have you been tested for sickle cell traits? **Y N**
* If yes, results _____
If you are Jewish have you been tested for Tay Sachs disease? **Y N**
* If yes, results _____
Do any women in your family suffer from osteoporosis/hip fractures? **Y N** If yes, who _____

Are there any inherited diseases in your family such as Hemophilia, MS, Cystic Fibrosis? **Y N**
* If yes, who _____

Are there any birth defects or open spine defects (spina bifida, aencephaly) Y N
* If yes, who _____

DIET

- ☐ Regular
- ☐ Special _____
- ☐ Are you a vegetarian? **Y N** Do you consume dairy? **Y N** Fish? **Y N**
- ☐ Do you use any herbal supplements at all? **Y N** If yes, type _____
- ☐ Do you take calcium daily? **Y N** If yes, how much _____
- ☐ Do you exercise regularly? **Y N** If yes, type _____

OBSTETRICAL HISTORY

- ☐ None

Number of pregnancies _____ How many deliveries? _____

How many living children? _____ How many miscarriages? _____

How many abortions? _____ How many vaginal deliveries? _____ C-section? _____

FERTLITY HISTORY
Do you intend to get pregnant? **Y N** When do you plan to try? _____
How long have you and your partner been attempting pregnancy? _____
Have you been treated for infertility previously? **Y N**
If yes, where and when? _____

Which tests have been performed?

☐ Basal body temperature	☐ Infection test (ureaplasma, mycoplasma)	☐ Estradiol
☐ Post coital test	☐ Endometrial biopsy	☐ FSH
☐ Clomid challenge test	☐ Hysterosalpingogram	☐ DHEAS
☐ Sonohysterogram	☐ Antibody tests	☐ Thyroid
☐ Testosterone	☐ Ultrasound	

Have you ever taken any of the following?

☐ Clomid ☐ Letrazole ☐ HcG (Ovidrel)
☐ Injectible Gonoadotropins ☐ Progesterones ☐ Progestins
☐ Estrogens ☐ Testosterone

Have you ever attempted intrauterine insemination? **Y N**
If yes, how many times: _____ Dates: _____
Was specimen provided by ☐ Donor ☐ Partner

Have you ever attempted in vitro fertilization? **Y N**
If yes, how many times? _____

Has your male partner had any of the following tests done?
☐ Semen analysis ☐ Chromosome test ☐ Chlamydia
☐ Testicular biopsy ☐ Hormonal test ☐ Xray of testes

Has your male partner ever had surgery involving the reproductive tract?
☐ Varicocele repair ☐ Vasectomy ☐ Vasectomy reversal
☐ Hernia repair ☐ Repair of obstruction of vas deferens
☐ Prostate surgery ☐ Hernia repair ☐ Testicular torsion repair

Has your male partner ever had significant testicular injury? **Y N**
If yes, explain _____

Patient history reviewed by Dr. _____

Physician signature: _____

Date: _____