Rassetti Gynecology

HISTORY AND PHYSICAL EXAMINATION

TODAY’S DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ht: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to Dr. Ramirez? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Cause of Death | Age |
| Father  | Living / Deceased |  |  |
| Mother | Living / Deceased |  |  |
| Number of Siblings | #living\_\_\_/ #Deceased\_\_\_ |  |  |

**Do you have a Family History of:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **If yes, which family member (indicate paternal or maternal** |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |
| Diabetes |  |  |  |
| Stroke |  |  |  |
| Cancer |  |  |  |
| If yes location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Thyroid Disease/ Cancer |  |  |  |
| Other diseases |  |  |  |

**Review of Your Body Systems: Do you have now or have you ever had any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Please Explain** |
| Anemia |  |  |  |
| Arthritis |  |  |  |
| Blood Transfusions |  |  |  |
| Bowel Disorders |  |  |  |
| Breast Disease |  |  |  |
| Cancer |  |  |  |
| Chicken Pox |  |  |  |
| Diabetes |  |  |  |
| DES Exposure |  |  |  |
| Endometriosis |  |  |  |
| Excessive Bleeding |  |  |  |
| Gall Bladder |  |  |  |
| H. Hernia/Peptic Ulcer |  |  |  |
| Headache/ Migraine |  |  |  |
| Heart Disease |  |  |  |
| Hypertension |  |  |  |
| Infertility |  |  |  |
| Jaundice/ Hepatitis |  |  |  |
| Kidney Disease |  |  |  |
| Respiratory Disease |  |  |  |
| Psych. Illness/Depression |  |  |  |
| Seizure Disorder |  |  |  |
| Skin Disease |  |  |  |
| Thyroid Disease |  |  |  |
| Urinary Infections |  |  |  |
| Varicose Veins/ Phlebitis |  |  |  |

**Past Surgical History:**

|  |  |
| --- | --- |
| **Date** | **Procedure** |
|  |  |
|  |  |
|  |  |
|  |  |

**Illness History (other than Surgical Procedures):**

|  |  |
| --- | --- |
| **Date** | **Procedure** |
|  |  |
|  |  |
|  |  |

**Tests:** (give date last done)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Test** | **Year Performed** | **Not Sure** | **Never Done** | **Results** |
| Pap Smear |  |  |  |  |
| Breast Exam |  |  |  |  |
| Mammogram |  |  |  |  |
| Rectal exam |  |  |  |  |
| Sigmoidoscopy |  |  |  |  |
| Cholesterol |  |  |  |  |
| Rubella |  |  |  |  |
| Triglycerides |  |  |  |  |
| Thyroid Profile |  |  |  |  |
| Tetanus (DTP) |  |  |  |  |
| Bone Density |  |  |  |  |
| Other\_\_\_\_\_\_\_\_ |  |  |  |  |

**Menstrual Period**: (if Apply)

Age Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems with Breasts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unusual Vaginal Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periods: Regular: \_\_\_ Irregular:\_\_\_ Difficulty with Periods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancies:** (if Apply)

# of Children Born Alive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Cesarean Sections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Premature Births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of stillborns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Abortions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Personal Habits:** (Do you?)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Please Explain** |
| Do you exercise regularly ( 3 to 4 times per week)? |  |  |  |
| Do you use illegal drugs? |  |  |  |
| Do you use alcohol? |  |  |  |
| Were you ever a heavy drinker? |  |  |  |
| Do you smoke? |  |  |  |
| If ever, when did you stop? |  |  |  |
| Do you have an eating disorder? Anorexia\_\_\_\_ Bulimia\_\_\_ |  |  |  |
| Have you ever been physically abused? |  |  |  |
| Do you feel safe in your home? |  |  |  |
| Any Concerns? |  |  |  |
|  |  |  |  |

**My signature indicates that the above information is true and correct to the best of my knowledge.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Signature**