advocare | Center for Specialized Gynecology

Patient Name: _____ Age: _____ Date: _____

Referring Physician: _____
(If any) Name Address Phone number

Personal History

Medication Allergy: ❑ Yes ❑ No List: _____
Iodine Allergy: ❑ Yes ❑ No Latex Allergy: ❑ Yes ❑ No

Medications:	Dosage	How Often	Medications:	Dosage	How Often

Prior Hospital/Surgery: Year Hospital

Social History

Do you smoke? ❑ Yes ❑ No Amount: _____ Do you drink alcohol? ❑ Yes ❑ No Amount: _____
Occupation: _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Family History

	Medical Problems	Living	Age	Deceased	Cause of Death
Mother:					
Father:					
Siblings:					
Other:					

Review Of Systems

Do you now or have you had any problems related to the following? Circle Yes or No. Please explain any Yes answers on page 2.

Allergic/Immunologic

Hay Fever	Y	N
Other:_____		

Cardiovascular

Chest Pain	Y	N
High Blood Pressure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
Swelling of Feet or Ankles	Y	N
Heart Palpitations	Y	N
Varicose Veins	Y	N
Phlebitis	Y	N
Heart Failure	Y	N
Rheumatic Fever	Y	N
Other:_____		

Constitutional Systems

Fever	Y	N
Fatigue	Y	N
Chills	Y	N
Headache	Y	N
Other:_____		

Eyes

Glaucoma	Y	N
Blurred Vision	Y	N
Double Vision	Y	N
Other:_____		

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Loss of Appetite	Y	N
Change in Bowels	Y	N
Constipation	Y	N
Diarrhea	Y	N
Rectal Bleeding	Y	N
Irritable Bowel	Y	N
Colitis	Y	N
Diverticulitis	Y	N
Liver Disease	Y	N
Hepatitis	Y	N
Other:_____		

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Urinary Urgency	Y	N
Blood in Urine	Y	N
Frequent Infections	Y	N
Stones	Y	N
Difficult Voiding	Y	N
Incontinence	Y	N
Sexually Transmitted Infection	Y	N
Bladder Repair Surgery	Y	N
Other:_____		

Endocrine

Excessive Thirst	Y	N
Thyroid Disease	Y	N
Diabetes	Y	N
Hormone Problem	Y	N
Too Hot/Cold	Y	N
Hair Loss	Y	N
Excessive Hair Growth	Y	N
Other:_____		

Circle Yes or No. Please explain any Yes answers in space provided.

Ears/Nose/Mouth/Throat

Hearing Loss	Y	N
Ear Infection	Y	N
Sinus Problems	Y	N
Nose Bleeds	Y	N
Sore Throat	Y	N
Pain	Y	N
Swollen Glands in Neck	Y	N

Other:_____

Musculoskeletal

Joint Pain/Swelling	Y	N
Neck Pain	Y	N
Back Pain/Problems	Y	N
Arthritis	Y	N
Gout	Y	N
Muscle Weakness	Y	N

Other:_____

Respiratory

Chronic Cough	Y	N
Spitting up Blood	Y	N
Asthma, Wheezing	Y	N
Bronchitis	Y	N
Emphysema	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N

Other:_____

Gynecologic

No. of Pregnancies	_____	
Abnormal Pap	Y	N
Abn. Mammogram	Y	N
Pelvic Pain	Y	N
Irregular Menses	Y	N
Cramps	Y	N
Endometriosis	Y	N

Neurological

Tremors	Y	N
Numbness/Tingling	Y	N
Headaches	Y	N
Migraines	Y	N
Fainting	Y	N
Seizures	Y	N
Light Headed/Dizzy	Y	N
Stroke	Y	N
Parkinson's Disease	Y	N

Other:_____

Integumentary

Skin Rash	Y	N
Persistent Itch	Y	N

Other:_____

Breast

Masses	Y	N
Cysts	Y	N
Pain	Y	N
Nipple discharge	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Prob	Y	N
Anemia	Y	N
Past Transfusions	Y	N
Easy Bleeding/Bruising	Y	N

Other:_____

Psychiatric

Memory Loss	Y	N
Depression	Y	N
Anxiety	Y	N
Insomnia	Y	N

Other:_____

How did you hear about us?

❑Friend _____
Friend's Name

❑Relative _____
Relative's Name

❑Ad _____
Publication's Name

❑Other

Explanation of Yes answers: (from pages 1 & 2)

Details of ROS (To be completed by Physician)