ADVANCED gynecology Specialists of Augusta

Detailed Health History

Today's Date: _____

Patient's Name _____ Date of Birth: _____

Reason for Visit: ☐ Routine Annual ☐ Problem (please describe): _____

MEDICAL HISTORY

Please review this sheet and mark any condition you have or have had in the past. If you are uncomfortable answering any of these questions, leave them blank. You can discuss them with Dr. Thaxton or his nurse

☐ I have reviewed the information on this page and I have no past medical history to report.

Breast	Yes	No
Breast cancer		
Fibrocystic breast disease		
Breast lumps		
Other:		
Cancer of	**Yes**	**No**
Colon		
Ovary		
Skin		
Uterus		
Other:		
Cardiovascular	**Yes**	**No**
Hypertension		
Heart attack		
High cholesterol		
Mitral valve prolapse		
Other:		
Dexa/Mamm/Pap (provide date)	**Yes**	**No**
Dexascan		
Mammogram		
Other:		
Digestive	**Yes**	**No**
Stomach ulcer		
Colitis		
Reflux disease		
Hepatitis		
Other:		

Gynecologic	Yes	No
Fibroid tumors		
Endometriosis		
Ovarian cysts		
Sexually transmitted diseases		
Cancer/pre-cancer cervix		
Other:		
Injury/Poisonings	**Yes**	**No**
Motor vehicle accident		
Pelvic fractures		
Hip fractures		
Other:		
Hematologic	**Yes**	**No**
Anemia		
Sickle cell		
Clots in legs or pelvis		
Von Willebrand Disease		
Factor V Leiden		
Pulmonary embolism		
Other:		
Musculoskeletal	**Yes**	**No**
Arthritis		
Rheumatoid arthritis		
Systemic lupus		
Osteoporosis		
Other:		

Neurologic	Yes	No
Seizures		
Migraines		
Strokes		
Other:		
Psychiatric	**Yes**	**No**
Depression		
Anxiety disorder		
Schizophrenia		
Other:		
Respiratory	**Yes**	**No**
Emphysema COPD		
Asthma		
Other:		
Urologic	**Yes**	**No**
Kidney stones		
Incontinence		
Other:		
Please list any conditions not shown		

FAMILY HISTORY

Please check yes or no on all that apply and indicate which relative was affected

Gynecologic	Yes	No	Relationship
Endometriosis			
Fibroids			
Cancer-Uterus			
Cancer-Ovary			
Cardiovascular	**Yes**	**No**	**Relationship**
Hypertension			
Heart attack			
Neurologic	**Yes**	**No**	**Relationship**
Stroke			

Respiratory	Yes	No	Relationship
Cancer-Lung			
Psychiatric	**Yes**	**No**	**Relationship**
Depression			
Hematologic	**Yes**	**No**	**Relationship**
Sickle Cell			
Leukemia			
Clots in legs			
Bleeding disorder			

Gastroenterology	Yes	No	Relationship
Cancer-Colon			
Breast	**Yes**	**No**	**Relationship**
Cancer-Breast			
Other:			

SURGICAL HISTORY
Please list all surgeries you have had

Surgery	Date	Surgery	Date

ALLERGIES

Do you have any allergies to medications, x-ray dyes, chemicals, etc.? ☐ Yes ☐ No If yes please provide details below.
Are you allergic to latex? ☐ Yes ☐ No
Have you or a family member ever had a reaction to anesthesia? ☐ Yes ☐ No If yes, please describe_____

Allergy	Reaction	Allergy	Reaction

MEDICATIONS YOU ARE TAKING
Please list medications you are currently taking

Drug Name	Dosage	Physician	Drug Name	Dosage	Physician

REPRODUCTION/MENSTRUAL HISTORY

Age when you had first period?	Cycle interval?
Periods last how many days?	Date of your last menstrual cycle?
Menopausal ☐ Yes ☐ No	Birth control method?

OBSTETRIC HISTORY

Total pregnancies?	Premature deliveries (less than 37 weeks): ☐ Yes ☐ No
Miscarriages ☐ Yes ☐ No Indicate how many	How many full term births (more than 37 weeks)?
Pregnancy Terminated? ☐ Yes ☐ No	Number of living children?

PREGNANCY HISTORY
Please provide information for each pregnancy, including abortions and miscarriages

Number	Date of Birth	Weeks gestational age	Sex	Weight	Vaginal or C Section	Complications
1						
2						
3						
4						
5						

SOCIAL HISTORY

Are you sexually active? ☐ Yes ☐ No	Do you have pain with intercourse? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No Number of times weekly?	Do you perform monthly self breast examinations? ☐ Yes ☐ No
Level of exercise? ☐ Fair ☐ Moderate ☐ Good	Do you drink alcohol? ☐ Never ☐ Minimal ☐ Moderate ☐ Heavy
Have you been a victim of domestic violence? ☐ Yes ☐ No	Do you smoke? ☐ Yes ☐ No ☐ Never ☐ Past How many per day?

Patient or Guardian (if under 18) Signature

Patient or Guardian Printed Name