Precision Vascular & Interventional

**Name**_____

**General Patient Questions** **Age**_____

**Reason for Visit**_____

| **Gynecology Medical History** | | |
|---|---|---|
| Number of pregnancies | | |
| Number of births | | |
| Number of miscarriages | | |
| Number of abortions | | |
| Number of children | | |
| Number of days per period | | |
| Number of pads/day | | |
| Number of tampons/day | | |
| Date of last period | | |
| Date of last pap smear | | |
| Trying to get pregnant | Yes | No |
| Plan to get pregnant if future | Yes | No |
| Heavy menstrual periods | Yes | No |
| Passing clots | Yes | No |
| Spotting between periods | Yes | No |
| Pain with periods | Yes | No |
| Pain between periods | Yes | No |
| Pelvic pressure | Yes | No |
| Pain during intercourse | Yes | No |

| | | |
|---|---|---|
| Pain after intercourse | Yes | No |
| Back pain | Yes | No |
| Frequent urination | Yes | No |
| Constipation | Yes | No |
| Symptoms have lasted months | Yes | No |
| Symptoms have lasted years | Yes | No |
| Symptoms getting worse | Yes | No |
| Anemia | Yes | No |
| Taking iron | Yes | No |
| Blood transfusion | Yes | No |
| Prior hormone treatment | Yes | No |
| Current hormone treatment | Yes | No |
| Hot flashes | Yes | No |
| Night sweats | Yes | No |
| In menopause | Yes | No |
| Prior fibroid surgery | Yes | No |
| Ultrasound shows fibroids | Yes | No |
| MRI shows fibroids | Yes | No |
| | | |

| Prior Fibroid Treatments | Year |
|---|---|
| | |
| | |

| Doctor Notes |
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| **Activity Level** | |
|---|---|
| Fully active | 0 |
| Restricted in strenuous activity, able to do light work | 1 |
| Can walk, provide all self care, moves more than 50% while awake | 2 |
| Limited self care, confined to bed more than 50% while awake | 3 |
| Disabled, no self care, completely confined to bed or chair | 4 |

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| **General History** | | | | | | Comments |
|---|---|---|---|---|---|---|
| Arthritis | Yes | No | Hepatitis A | Yes | No | |
| Asthma | Yes | No | Hepatitis B or C | Yes | No | |
| Bleeding tendency | Yes | No | High blood pressure | Yes | No | |
| Cancer | Yes | No | High thyroid | Yes | No | |
| Breast | Yes | No | HIV / AIDS | Yes | No | |
| Colon | Yes | No | Keloid formation | Yes | No | |
| Lung | Yes | No | Kidney disease | Yes | No | |
| COPD / Emphysema | Yes | No | Liver disease | Yes | No | |
| Deep vein thrombosis | Yes | No | Low thyroid | Yes | No | |
| Diabetes | Yes | No | Lupus | Yes | No | |
| Dialysis | Yes | No | Pneumonia | Yes | No | |
| GERD / Ulcers | Yes | No | Seizure | Yes | No | |
| Heart attack | Yes | No | Stroke | Yes | No | |
| Heart failure | Yes | No | | | | |

| **Social History** | | | Type / Frequency / How long |
|---|---|---|---|
| Alcohol use | Yes | No | |
| Tobacco use | Yes | No | |
| Recreational drug use | Yes | No | |

| **Previous Hospitalizations** | Year |
|---|---|
| | |
| | |
| | |

| **Previous Surgery** | Year |
|---|---|
| | |
| | |
| | |

| **Active Medical Problems** | Onset |
|---|---|
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| | |

| **Allergies** | Symptoms |
|---|---|
| | |
| | |
| | |

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**Name**_____

| **Family History** | Alive | | Medical Problems |
|---|---|---|---|
| Mother | Yes | No | |
| Father | Yes | No | |
| Brother | Yes | No | |
| Sister | Yes | No | |
| | Yes | No | |
| | Yes | No | |

| **Medications** | Reason |
|---|---|
| | |
| | |
| | |
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| | |
| | |

| **Review of Systems** | **Circle all that apply** | | |
|---|---|---|---|
| **Constitutional Symptoms** | **Genitourinary** | **Neurological** | **Eyes** |
| Good general health | Painful urination | Frequent or recurring headaches | Wear glasses |
| Recent weight loss | Blood in urine | Light headed or dizzy | Wear contact lenses |
| Recent weight gain | Incontinence or dribbling | Numbness or tingling | Blurred or double vision |
| Fever | Kidney stones | Tremors | Cataracts |
| Chills | **Musculoskeletal** | Paralysis | **Ears / Nose / Mouth / Throat** |
| Fatigue | Back pain | **Allergic/Immunologic** | Hearing loss |
| **Cardiovascular** | Pain radiating down legs | Prior adverse reaction to: | Ringing in the ears |
| Palpitations | Hip pain | Penicillin or other antibiotics | Earaches |
| Chest pain or angina | Knee pain | Morphine or other narcotics | Sinus problem |
| Swelling of feet or ankles | Shoulder pain | Lidocaine or other anesthetics | Nose bleeds |
| Varicose veins | Joint stiffness | Aspirin or other pain remedies | Mouth sores |
| Deep vein thrombosis | Joint swelling | Iodine | Sore throat |
| Sores on feet or ankles | Muscle weakness | Betadine | Swollen glands in neck |
| Leg cramps walking | Muscle cramps | **Skin / Breast** | **Psychiatric** |
| **Gastrointestinal** | **Respiratory** | Rash | Memory loss |
| Loss of appetite | Chronic cough | Breast pain | Nervousness |
| Nausea or vomiting | Shortness of breath | Breast discharge | Depression |
| Diarrhea | Wheezing | Breast lump | Confusion |
| Constipation | **Endocrine** | **Hematologic/Lymphatic** | Insomnia |
| Blood in bowel movements | Hormone problem | Slow to heal after cuts | |
| Abdominal pain | Excessive thirst | Easy bruising | |
| | Heat or cold intolerance | | |