Regine MD
2005 Midway Road Suite A
Menasha, WI 54952

Gynecology Medical History for Minimally Invasive Laser Procedures

Name:_____**ID#**_____

Date: _____/_____/_____

Phone 1: _____ **Phone 2:** _____

Primary Care MD _____ **Office Phone:**_____

Age:
_____

Date of birth: _____/_____/_____

Last pelvic exam:
____/_____/_____

Last pap smear
_____/_____/_____

Marital or relationship status:
☐ **Single** ☐ **Married** ☐**Long-term relationship**
☐ **Divorced** ☐ **Widowed**

Reason for consultation: _____

Past Ob/GYN surgeries or procedures including mammogram

	Date	Procedure	Surgeon
1.	____/_____/_____	_____	_____
2.	____/_____/_____	_____	_____
3.	____/_____/_____	_____	_____
4.	____/_____/_____	_____	_____

Past surgeries or cosmetic procedures (not Ob/Gyn)

	Date	Procedure	Surgeon
1.	____/_____/_____	_____	_____
2.	____/_____/_____	_____	_____
3.	____/_____/_____	_____	_____
4.	____/_____/_____	_____	_____

Personal history

1. Do you smoke? ☐ Yes ☐ No If yes, _____ packs per day, from what age_____
2. What is your daily consumption of alcohol? _____
3. Do you have any of allergies? (check all that apply) ☐ medications ☐ latex ☐ food ☐ plants ☐ anesthesia ☐ other_____
4. Do you have any issues with bruising or bleeding? ☐ Yes ☐ No
5. Do you exercise regularly? ☐ Yes ☐ No
6. Have you ever had an issue with your nerves or muscles? (strokes, temporary paralysis, Bell's Palsy nerve injuries, etc. ☐ Yes ☐ No If yes, describe _____
7. Do you need to take antibiotics before procedures such as dental? ☐ Yes ☐ No
8. Do you get fever blisters often? ☐ Yes ☐ No
9. Have you ever been treated for depression or other mental concerns? ☐ Yes ☐ No
10. Do any diseases run in your family? ☐ Yes ☐ No
11. Do you take any of the following?

☐ Antibiotics	☐ Anti-depressants
☐ Anti-coagulants	☐ Aspirin or Ibuprofen
☐ Blood pressure meds	☐ Hormone/contraceptives
☐ Cortisone or steroids	☐ Insulin
☐ NSAIDS	☐ Thyroid medication
☐ Sedatives	☐ Other_____

13. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

Medical History

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

_____

2. Do you have any of the following?

☐ Arthritis	☐ Bleeding disorders	☐ Breathing issues
☐ Any active infection	☐ Bruising	☐ Back pain
☐ Blood clots	☐ Cancer	☐ Chest pain

☐ Diabetes ☐ Epilepsy or seizures ☐ Heart disease
☐ Hepatitis ☐ High blood pressure ☐ Thyroid disease
☐ Herpes simplex ☐ HIV / Aids ☐ Other_____

Menstrual history

1. Age of first period: _____years
2. If your menstrual periods are regular: periods start every: _____days
3. If your menstrual periods are irregular, periods start every:____ to_____ days
4. Duration of bleeding: _____days
5. Duration of bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
7. First day of last menstrual period___/___/____
8. Is pain associated with periods? ☐ Yes ☐ No ☐ occasionally
9. If yes to 8, is it: before menses? ☐ during menses ☐ both ☐

Pregnancy history

10. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
11. Are you breastfeeding? ☐ Yes ☐ No
12. Number of pregnancies: _____ Live births _____ Abortions _____ Miscarriages _____ C-sections_____
13. Explanation and dates: _____

Contraceptive history

1. What birth control method(s) do you currently use? _____

Sexual history

1. Do you have a sexual partner? ☐ Yes ☐ No ☐ male ☐ female
2. Are there concerns about your sexual activity which you may want to discuss with your doctor? ☐ Yes ☐ No

Please check if you have any of these symptoms

☐ hot flashes ☐ night sweats ☐ pain with intercourse
☐ vaginal dryness ☐ spotting after intercourse ☐ other_____
☐ urine leakage _____
☐ when coughing? _____
☐ when laughing?
☐ when lifting or other activity?

3. **Please check if you have any of the following today:**
   ☐ Active urinary infection
   ☐ Active fungal infection

I have answered the questions contained in this questionnaire to the best of my knowledge.
I understand that it is my responsibility to inform my practitioner of my past and current health conditions as it pertains to the treatment I am seeking.

Signature: ____ Date: _____________