Penn Medicine Princeton Health

**GYNECOLOGY & MINIMALLY INVASIVE GYNECOLOGIC SURGERY**

New Patient Information Form

**PLEASE DOWNLOAD & COMPLETE THIS FORM (PDF or PRINT) – THEN EMAIL TO**

PMPH-GynSurgery@pennmedicine.upenn.edu

Patient Name_______________________________________________________ DOB:______________________

Preferred Name (if different) ________________________________ Gender _____________________________

What is the reason for your visit today? ____________________________________________________________

Who is your referring physician? ______________________ Your Primary Care MD? _________________________

Preferred phone number: _________________________________ Confidential voice mails OK: [] YES [] NO

**Menstrual History** (complete even if post-menopausal or no longer having periods)

Age at First Period: ___________________

If your menstrual periods are regular; periods start every: _______________ days

If your menstrual periods are irregular; periods start every: ______ to ______ days (e.g. 12 to 60)

Duration of bleeding: ____________ days

Does bleeding or spotting occur between periods? [] Yes [] No

Does bleeding or spotting occur after intercourse? [] Yes [] No

First day of last menstrual period (MM/DD/YYYY) ________________________

Is pain associated with periods? [] Yes [] No [] Occasionally How severe on scale 1-10 (10 highest) ______

If yes, is it: [] before menses? [] during menses? []both?

**Pregnancy History** (all pregnancies) **[] Have never been pregnant**

*Obstetrical History, including Abortions and Ectopics (tubal) pregnancies*

| Year | Duration of Preg. | Type of Delivery | Complications Mother/Baby |
|---|---|---|---|
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**Birth Control History**

What Birth Control method(s) do you currently use? ________________________________________________

**Sexual History**

Have you ever had a sexual partner? [] No [] Yes ( [] Male [] Female [] Both )

Are there concerns about your sexual activity which you may want to discuss with your doctor? [] Yes [] No

**Social History**

Sexual Orientation Identity: [] Heterosexual [] Gay [] Bisexual [] Lesbian [] Queer [] Not sure [] Other: ____________

Current Relationship Status: ________________________________

Do you currently smoke? [] No [] Yes - How many packs per day? ______

Do you use smokeless tobacco? [] No [] Yes

Please complete other side →

Do you drink alcohol? [] No [] Yes - How much? _____

Occupation: ____________________________________________________

**GYN Update**

Last pap smear _____________________ (month/year)

Have you had any other abnormal pap smears? [] No [] Yes

Have you had treatment for abnormal smears? [] No [] Yes (indicate year): Cryo _____ Cone ______ LEEP ______

Last mammogram ___________________ (year)

Last colonoscopy ____________________ (year)

Last bone density exam _______________ (year)

HPV/Gardasil Vaccine series completed? [] Yes [] No

**Other GYN History:** Check any that apply None

| | | |
|---|---|---|
| [] Genital Warts | [] Fibroids | [] Vulvar Pain |
| [] Gonorrhea/Chlamydia | [] Pelvic Inflammatory Dz | [] Vaginal Infections |
| []Endometriosis | [] Recurrent UTIs | [] Other ________________ |

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**Past Obstetrical/Gynecological Surgeries:** Check any that apply [] None

| SURGERY | YEAR | SURGERY | YEAR |
|---|---|---|---|
| [] D&C | _______ | [] Ovarian Surgery | _______ |
| [] hysteroscopy | _______ | [] L cysts(s) removed ovarian | _______ |
| [] infertility surgery | _______ | [] R cysts(s) removed ovarian | _______ |
| [] tubal ligation | _______ | [] L ovary removed | _______ |
| [] laparoscopy | _______ | [] R ovary removed | _______ |
| [] myomectomy | _______ | [] surgery for prolapse/incontinence | _______ |
| [] hysterectomy | _______ | [] cesarean section (s) | _______ |
| [] cervix removed [] ovaries removed | | [] other (specify)________________________________ | |

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**Past Medical History:** Check any that apply [] None

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|---|---|---|
| [] High Blood Pressure | [] Diabetes | [] Heart Attack or Angina |
| [] Stroke | [] Pacemaker or Defibrillator | [] High Cholesterol |
| [] Kidney Problems | [] Asthma or Lung Disease | [] Cancer (specify type____________) |
| [] Thyroid Problems | [] Depression | [] HIV + |
| [] History of Blood Transfusions | [] Anxiety | [] Other _______________________ |
| [] Hx Blood Clots | [] Eating disorder | _______________________ |

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**Previous Surgeries:** Please list all that apply, and the dates to the best of your recollection [] None

| SURGERY | YEAR |
|---|---|
| ________________________________________ | ____________________________ |
| ________________________________________ | ____________________________ |
| ________________________________________ | ____________________________ |

Please complete other side →

**Family History:** If "yes" to any, please list affected relatives below. [] None

[] Breast Cancer ___________________ [] Cervical Cancer __________________ [] Diabetes ______________________

[] Ovarian Cancer __________________ [] Colon Cancer ____________________ [] Heart Disease __________________

[] Uterine Cancer __________________ [] Lung Cancer _____________________ [] Other _________________________

___________________________________ _________________________________ _________________________________

___________________________________ _________________________________ _________________________________

**Medications:** (List ALL over-the-counter, herbal or alternative medications)

| Medication & Dosage | Frequency | Medication & Dosage | Frequency |
|---|---|---|---|
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**ALLERGIES (and Reaction)**: ___________________________________________________________________________

**Review of symptoms:** Are you currently having problems with any of the following?

**General**
Chills
Fatigue
Fever
Weight Loss
Weight Gain

**Heart**
Chest Pain
Palpitations
Leg Swelling

**Lungs**
Cough
Shortness of Breath
Coughing blood

**HEENT**
Blurry Vision
Eye Pain
Sensitivity to Light
Nasal Congestion
Sore Throat
Sinus Infection

**Gynecologic**
Heavy Periods
Irregular Periods
Painful Periods
Prolonged Periods
Pain with Ovulation
Pain with Sex
Acne
Mood Swings
Hot Flashes
Night Sweats
Difficulty Concentrating

**Endocrine**
Heat Intolerance
Cold Intolerance
Excessive Thirst

**Neurologic**
Dizziness
Headaches
Seizures
Tremor

**Gastrointestinal**
Abdominal Pain
Acid Reflux
Loss of Appetite
Trouble Swallowing
Constipation
Diarrhea
Heartburn
Vomiting Blood
Blood in Stool
Black Stool
Nausea
Vomiting

**Blood/Lymph Nodes**
Easy Bruising
Easy Bleeding
Swollen Lymph Nodes

**Allergy/Immune System**
Seasonal Allergies
Food Allergies
Chemicals Exposures

**Urinary**
Painful Urination
Blood in Urine
Urinary Frequency
Urine Incontinence
Urine Retention

**Psychiatric**
Anxiety
Depression
Stress

**Muscles & Joints**
Joint Pains
Back Pain
Muscle Aches

**Skin**
Jaundice
Hives
Rash

Please complete other side →

**ANY ADDITIONAL INFORMATION:**

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Please complete other side →