Vermont Urogynecology Associates, PC

PATIENT HISTORY

Name: _____ DOB: _____

I Social History

1. **Education:**

   ☐ High school completed ☐ More than high school

2. **Living Status:**

   ☐ Single ☐ Married ☐ Widowed ☐ Civil Union

3. **Do you drink alcohol?**

   ☐ Yes ☐ No

   If yes, indicate amount per day (beer, wine or liquor): _____

4. **Do you drink caffeinated beverages?**

   ☐ Yes ☐ No

   If yes, indicate amount per day (coffee, tea or soda): _____

5. **Smoking Status:**

   ☐ Never ☐ Former ☐ Current

   If current, ☐ Everyday ☐ some days

II Family History

Problem:	**Affected Relative:**
☐ Bleeding disorder	_____
☐ Diabetes	_____
☐ Heart disease	_____
☐ High lipids	_____
☐ Cardiovascular disease	_____
☐ Thyroid disease	_____
☐ Osteoporosis	_____
☐ Bladder Cancer	_____
☐ Kidney Cancer	_____
☐ Ovarian Cancer	_____
☐ Uterine Cancer	_____
☐ Colon Cancer	_____
☐ Breast Cancer	_____
☐ High blood pressure	_____

III Medical History

1. **Date of last complete medical exam:**

   ☐ Within past year ☐ More than one year

2. **Allergies: Medications, foods, other:**

   Substance allergic to: **Reaction:**

   _____

   _____

   _____

3. **Which, if any, of the following have you been treated for:**

☐ Alcoholism/drug abuse	☐ Constipation	☐ Glaucoma
☐ Alzheimer's/dementia	☐ Coronary artery disease	☐ Hearing loss
☐ Anemia	☐ Depression	☐ Head injury
☐ Arthritis	☐ Diabetes	☐ High blood pressure
☐ Congestive heart failure	☐ Emphysema	☐ Irritable bowel syndrome
☐ Back pain	☐ Esophageal reflux	☐ Kidney stones
☐ Bleeding problems	☐ Cataracts	☐ Bladder disease
☐ Cancer type: _____	☐ Fractures/Location_____	☐ Kidney disease
☐ Heart murmur	☐ High lipids	☐ Irregular heart beat
☐ Neurologic disease type: _____	☐ Osteoporosis	☐ Seizures
☐ Psychiatric disease type: _____	☐ Recurrent urinary tract infections	☐ Stroke
☐ Thyroid disease	☐ Vascular disease	

☐ Skin sensitivities or conditions type: _____

4. **Prior Obstetric/Gynelogic History:**

   - Date of last period: _____

     ☐ Naturally postmenopausal ☐ Surgically postmenopausal

   - Current method of birth control:

     ☐ None ☐ Tubal ☐ Vasectomy ☐ IUD

     ☐ Oral Contraceptives ☐ Other: _____

   - Number of pregnancies: _____
   - Number of vaginal deliveries: _____
   - Number of cesarean sections: _____

5. **Health Screening History:**

   - Date of last pap smear: _____

☐ History of abnormal pap smear
Year and treatment: _____

- Date of last mammogram: _____

☐ History of abnormal mammogram
Year and treatment: _____

- Date of last colonoscopy: _____

☐ History of abnormal colonoscopy
Year and treatment: _____

- Date of last bone density: _____

☐ History of abnormal bone density
Year and treatment: _____

6. List all medications you are currently taking (prescription and over the counter):

Name	Dosage	Reason for Taking

7. Previous Surgeries:

Date	Type of Surgery