DEPARTMENT OF OBSTETRICS, GYNECOLOGY
AND REPRODUCTIVE MEDICINE

Stony Brook Medicine
University Physicians

OUTPATIENT MEDICAL HISTORY

Reason for Today's Visit:

OBSTETRICAL HISTORY

Number of Pregnancies:
Full Term: _____ Pre-term _____ Miscarriage/Abortion _____ Number of living children _____

Type of Deliveries and Dates: _____

Pregnancy or Delivery Complications: _____

MEDICAL HISTORY

Do you have or have you ever experienced any of the following? (If yes, please provide details):

- ❒ Heart Disease or High Blood Pressure _____
- ❒ Intestinal Colitis or Gall Bladder Disease _____
- ❒ Urinary Tract Infections or Stones _____
- ❒ Musculoskeletal, osteoporosis or arthritis _____
- ❒ Cancer _____
- ❒ Lung Disease or Asthma _____
- ❒ Emotional Problems _____
- ❒ Psychological Problems _____
- ❒ Endocrine, Diabetes or Thyroid _____
- ❒ Other _____

When did you have your cholesterol level determined last? _____

Allergies: _____

_____ What reaction?: _____

Medications, Vitamins and Nutritional/Herbal Supplements Currently Taking: _____

_____

_____

SURGICAL HISTORY

Year	Hospital	Doctor	Operation	Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL HISTORY

	No	Yes	If yes, # years / stopped # years
Cigarettes	❒	❒	_____
Alcohol	❒	❒	_____
Occupational Hazards:	❒	❒	_____

Current exercise activities: _____

_____

Are you a victim of physical or mental abuse: _____

FAMILY HISTORY

History of cancer, heart disease, hypertension, osteoporosis?
Mother _____

_____

Father _____

_____

Siblings _____
Children _____
Other _____

CONTINUED ON REVERSE ➔ ➔ ➔

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OUTPATIENT MEDICAL HISTORY – Page 2

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY
Last Period: _____ Number of Days Bleeding: _____
Age Began: _____ Number of days between periods: _____
Any changes: _____ Problems: _____

CONTRACEPTION
Current Method of Birth Control: _____
Have you ever used: Pills _____ Diaphragm _____ IUD _____

POST MENOPAUSAL HISTORY
Are you having problems with the following:
❒ Depression ❒ Flashes or Flushes ❒ Insomnia
❒ Vaginal Discharge ❒ Vaginal Dryness ❒ Changes in Sexual Function or Discomfort

SEXUALLY TRANSMITTED DISEASE HISTORY
❒ Herpes _____ ❒ Condylomata (venereal warts) _____
❒ Chlamydia _____ ❒ Syphilis _____
❒ Possible exposure to HIV/AIDS _____

	Normal	Abnormal
Date of last Pap _____	❒	❒
Date of Last Mammogram _____	❒	❒
Date of last Bone Density Test _____	❒	❒
Date of last Colonsocopy/Sigmoidoscopy _____	❒	❒

REVIEW OF SYSTEMS (PLEASE CHECK "YES" OR "NO" IF YOU ARE ***CURRENTLY*** HAVING PROBLEMS WITH THE FOLLOWING:

	YES	NO	COMMENTS		YES	NO	COMMENTS
Constitutional				**Genitourinary**			
Fever, sweats or chills				Difficult/painful urination			
Anorexia or weight change				Blood in urine			
Eyes				Strong/frequent urge to urinate			
Dry eyes or irritation				Involuntary urine loss			
Double vision				Increased urination at night			
Ears/Nose/Mouth/Throat				Abnormal bleeding			
Earaches/hearing loss				Painful periods/PMS			
Nose/sinus problems				Painful intercourse			
Dry mouth/mouth ulcers				Infertility			
Cardiovascular				**Neurological**			
Chest pain or pressure				Headaches			
Swelling of ankles				Weakness or numbness			
Rapid/irregular heartbeat				Loss of consciousness			
Respiratory				Dizziness or faintness			
Difficulty breathing w/ exertion				**Psychiatric**			
Cough/sputum				History of depression			
Shortness of breath				Anxiety			
Breast				Frequent crying			
Pain				Sleep disturbance			
Nipple discharge				**Endocrine**			
Lumps				Hair Loss			
Gastrointestinal				Abnormal thirst			
Heartburn/indigestion				Hot flashes			
Nausea/vomiting				Skin			
Constipation				Rashes or lesions			
Diarrhea				Sores or moles			
Bloody stool							
Recent stomach pain							

I have reviewed the two page Patient History as indicated above: _____

_____ _____ _____
Attending Signature ID # Date/Time