Department of Obstetrics, Gynecology and Reproductive Medicine

Stony Brook Medicine
University Physicians

Interim Medical History

Reason for Today's Visit:

INTERIM GYNECOLOGIC HISTORY

MENSTRUAL HISTORY
Last Period: _____________ Number of Days Bleeding: __________________
Are you having any menstrual problems? ____

CONTRACEPTION
Current Method of Birth Control: ____
Any Problems? ____

	Normal	Abnormal		Normal	Abnormal
Date of last Pap _________________________	❒	❒	Date of last Bone Density Test _______________	❒	❒
Date of Last Mammogram __________________	❒	❒	Date of last Colonsocopy/Sigmoidoscopy ________	❒	❒

INTERIM OBSTETRIC HISTORY

Number of Pregnancies: Full Term: _____ Pre-term _____ Miscarriage/Abortion _____ Number of living children _______
Type of Deliveries and Dates: ____

Pregnancy or Delivery Complications: ____

INTERIM MEDICAL HISTORY

New Medical Problems: ____

Allergies: ____

Surgeries Since Last Exam: ____

Medications, Vitamins and Nutritional/Herbal Supplements currently taking: ______________________________

Family History Updates: ____

Social History Updates: Smoking: Yes ❒ No ❒ Years: _________ Quit: ___________
Alcohol/Drug Use: Yes ❒ No ❒ Years: _________ Quit: ___________
Have you been a victim of mental or physical abuse? Yes ❒ No ❒

REVIEW OF SYSTEMS (PLEASE MARK WITH AN "X" 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 Patient History as indicated above: ____

_____________________________ ______________________ ______________________
Attending Signature ID # Date/Time