Serenity GYN & Functional Medicine

DEMOGRAPHICS

Name ________________________ **DOB** ______________ **Age** ________ **SSN:** ______________

Home # ________________ **Mobile #** ________________ **Email Address:** ________________

Address ________________________ **Apt #** ________**City** ____________ **State** ________ **Zip** ________

Driver's License # ______________________ **State** ____________

Employer's Name ________________________________ **Occupation** ______________________

Employer's Address ________________________________ **Phone #** ______________________

City ____________________________ **State** __________________ **Zip** ________________

Person to notify in case of emergency ________________ **Relationship** __________**Tel #**______________

Primary Physician's Name:______________________________ **Phone #:**__________________

Pharmacy: __________________________**City/Phone #:**______________________________

FINANCIAL INFORMATION

Primary Insurance Co._____________________________ Tel # __________________________

Insurance ID# __________________________ Group # ________________________________

Insured's Name ________________ Insured's Date of Birth __________ Relationship to Patient ____________

Secondary Insurance Co.____________________________ Tel # __________________________

Insurance ID# __________________________ Group # ________________________________

Insured's Name __________________ Insured's Date of Birth __________ Relationship to Patient __________

Patient Signature ________________________________ **Date** __________________________

Patient History Questionnaire

1. Reason for this visit: ____
2. Marital Status: Single Married Divorced Widowed
3. Medical History (**Please Circle All That Apply**): Heart Problems Diabetic
   High Blood Pressure High Cholesterol Fibromyalgia Migraine Headaches
   Depression/Anxiety Other: ____
   ____
4. Current Medications: ____
   ____

5. Allergies to medicine or food? ____

5. Age at first period: ______________.
6. Are your menstrual periods regular? ____
7. Duration of bleeding: _____ days
8. Does bleeding or spotting occur between periods? ______________________________
9. Does bleeding or spotting occur after intercourse? ______________________________
10. First day of last menstrual period ____
11. Is pain associated with periods? ____
    If so when: ____
12. Do you have a sexual partner? No ☐ Yes ☐ (Male ☐ Female ☐)
13. Are there concerns about your sexual activity which you may want to discuss with your doctor?

____

Review of Systems: (Please circle yes or no.)

General:

Changes in weight	Yes	No
Progressive/Prolonged Fatigue	Yes	No

Pulmonary:

Cough	Yes	No
Shortness of breath	Yes	No
Wheeze	Yes	No
Snoring	Yes	No

Cardiac:

Do you ever wake up short of breath	Yes	No
Leg/ Ankle swelling	Yes	No
Do you sleep okay	Yes	No
Palpitations / Heart flutters	Yes	No
Abnormal sensation with exertion/ (in chest, arms, neck, back)	Yes	No

Infectious Disease:

Fever	Yes	No
Night Sweats	Yes	No
Recent Infection	Yes	No

Gynecologic/Urologic:

Incontinence	Yes	No
Difficulty / Painful urination	Yes	No
Blood in urine	Yes	No

Psychiatric:

Suicidal thoughts	Yes	No
Hallucinations	Yes	No
Memory loss	Yes	No
Feeling depressed/anxious	Yes	No

Blood/Lymph:

Easy bruising	Yes	No
Frequent nose bleeds	Yes	No
Swollen glands	Yes	No

Head and Neck:

Decrease in hearing	Yes	No
Ringing in the ears	Yes	No
New Headaches	Yes	No
Sinus Problems	Yes	No
Sore throat	Yes	No
Changes in voice	Yes	No
Dry mouth	Yes	No

Eyes:

Blurred vision	Yes	No
Eye pain	Yes	No
Redness	Yes	No
Watering	Yes	No
Light sensitive	Yes	No
Dry feeling	Yes	No

Gastrointestinal:

Frequent Nausea / Vomiting	Yes	No
Abdominal pain	Yes	No

Skin:

Changing moles	Yes	No
New rash	Yes	No
Tendency to form Keloid	Yes	No

Neurological:

Dizziness	Yes	No
Difficulty walking	Yes	No
Sensory changes	Yes	No

Musculoskeletal:

Weakness / Numbness	Yes	No
Neck / Back Pain	Yes	No
TMJ / Jaw Pain	Yes	No

Surgical History

Gynecological Surgeries (circle all that apply): D&C Hysteroscopy Infertility Surgery Tuboplasty Tubal Ligation Laparoscopy Hysterectomy (vaginal) Hysterectomy (abdominal) Myomectomy Ovarian Surgery Ovarian Cyst(s) Removed Cesarean Section Vaginal or Bladder Repair for Prolapsed or Incontinence

All Other Surgeries:

____

____

____

Any problems with anesthesia? ____

Pap Smear/Mammogram History

1. Date of last Pap Smear: ________________________ Was it normal? ___________
2. Have you had treatment for abnormal pap smears? __________________________

   Cryotherapy   Laser   Cone Biopsy   Loop Excision (LEEP)

3. Date of last mammogram: _________________________ Was it normal? _________
4. Have you had any of the following? (circle all that apply)   Venereal warts   Syphilis

   Herpes – genital   Pelvic inflammatory disease   Endometriosis   Chlamydia

   Gonorrhea   Vaginal infections

Pregnancy History (All pregnancies)

Year	Full Term, Miscarriage or Abortion	Duration Pregnancy	Type of Delivery	Complications	Sex	Birth Weight	Present Health

Family & Social History

1. Do you smoke?   No   Yes _______________________ packs/day
2. Do you use alcohol?   No   Yes ____________________how often
3. Do you use recreational drugs?   No   Yes
4. Do you exercise? No   Yes ____
5. Height: ______________ Weight: __________
6. Do you have a family history of (who in your family):   Diabetes ____________________

   Ovarian Cancer ____________________   Heart Disease______________________

   Breast Cancer _____________________   Colon Cancer _______________________

   Other: ____