



# Arizona Specialized

## G Y N E C O L O G Y

Date: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Cell #: \_\_\_\_\_

### MEDICATIONS

List all medications & vitamins. Check here if none \_\_\_\_\_

Medication	Dose

### ALLERGIES

List all allergies. Check here if none \_\_\_\_\_

Allergies	Reaction

### SURGICAL HISTORY

Have you ever had any of the following (circle Y or N)

Appendectomy (removal of appendix)	Y / N	
Bladder Surgery	Y / N	
Breast Biopsy	Y / N	
Breast Implants / Reduction	Y / N	
Cesarean Section	Y / N	
Cholecystectomy (gallbladder removal)	Y / N	
Dilation & Curettage	Y / N	
Ectopic Pregnancy (tubal pregnancy)	Y / N	
Endometrial Ablation	Y / N	
Heart/Vascular	Y / N	
Hip	Y / N	
Hysterectomy	Y / N	
If YES what type of hysterectomy	Y / N	
Abdominal	Y / N	
Laparoscopic	Y / N	
Vaginal	Y / N	
Is your cervix still present?	Y / N	
Were your ovaries removed?	Y / N	
Hysteroscopy (viewing of uterus)	Y / N	
Knee	Y / N	
Laparoscopy	Y / N	
Colposcopy (viewing of the cervix)	Y / N	
LEEP/CKC	Y / N	
Mastectomy (removal of breasts)	Y / N	
Myomectomy (removal of fibroids)	Y / N	
Ovarian Cystectomy (removal of cysts)	Y / N	
Rectal	Y / N	
Shoulder	Y / N	
Tonsillectomy (removal of tonsils)	Y / N	
Tubal ligation ("tubes tied")	Y / N	
Other:	Y / N	

### MEDICAL HISTORY

Have you ever had any of the following (circle Y or N)

Uterine fibroids	Y / N
Endometriosis	Y / N
Infertility	Y / N
Polycystic ovarian syndrome	Y / N
Pelvic inflammatory disease	Y / N
Breast problem	Y / N
Breast Cancer	Y / N
Cervical cancer	Y / N
Uterine cancer	Y / N
Ovarian cancer	Y / N
Anemia	Y / N
Anesthesia complications	Y / N
Anxiety disorder	Y / N
Arthritis	Y / N
Asthma	Y / N
Birth Defect/Inherited disease	Y / N
Cancer	Y / N
Clotting disorder	Y / N
Deep vein thrombosis	Y / N
Depression	Y / N
Diabetes	Y / N
Gastrointestinal problems	Y / N
Headaches or migraines	Y / N
Heart conditions	Y / N
Hepatitis	Y / N
High blood pressure	Y / N
Kidney or bladder problems	Y / N
Lung disease	Y / N
Psychiatric illness	Y / N
Pulmonary embolus	Y / N
Thyroid problems	Y / N
Other:	Y / N

# ARIZONA SPECIALIZED GYNECOLOGY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SOCIAL HISTORY

Occupation:	
Will you accept blood transfusions?	Y / N
Sexually active?	Y / N
Marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
Sexual orientation <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual	
Do you or have you ever smoked?	Y / N
Number of packs/day	
Alcohol intake	Y / N
How many glasses/day	
Street drugs:	Y / N
Which ones:	
<input type="checkbox"/> Exercise <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently <input type="checkbox"/> All the time	

## FAMILY HISTORY

Does any family member have any of the following?  
(mother, father, sibling, child, grandfather, grandmother, aunt, uncle)

(Circle Y or N) Relation/Maternal or Paternal

Anemia	Y / N	M / P
Bleeding Disorder	Y / N	M / P
Breast Cancer	Y / N	M / P
Colon Cancer	Y / N	M / P
Diabetes	Y / N	M / P
Endometrial Cancer	Y / N	M / P
Heart problem	Y / N	M / P
Hypertension	Y / N	M / P
Osteoporosis	Y / N	M / P
Ovarian Cancer	Y / N	M / P
Stroke	Y / N	M / P
Uterine Cancer	Y / N	M / P
Pancreatic Cancer	Y / N	M / P
Other:	Y / N	M / P

## GYNECOLOGY HISTORY

Date of last menstrual period	
Age at first period	
Age at menopause if postmenopausal	
Current birth control method	
Other contraception methods used in the past	
History of STD	Y / N
If yes, diagnosis:	
Date of last Pap Smear	
Have you ever had an abnormal PAP?	Y / N
If yes, when and diagnosis:	
Treatment	
Date of last Mammogram	
Date of last Bone Density Scan	
Date of last Colonoscopy	

## OBSTETRIC HISTORY

Total Number of Pregnancies	
Number of Full Term Deliveries	
Number of Preterm Deliveries	
Number of Abortions	
Number of Miscarriages	
Number of Ectopic Pregnancies	
Birth Weight of Largest Infant	
Number of C-sections	
Number of Vaginal Deliveries	

Please **CIRCLE** all that apply: If you have none of the symptoms describing what the topic is, then select NO.

**Constitutional:** No Constitutional Symptoms; Fever Fatigue Significant Weight Gain/ Loss  
Other \_\_\_\_\_

**Cardiovascular:** No Cardiovascular Symptoms; Chest Pain Palpitations Shortness of Breath Swelling  
Other \_\_\_\_\_

**Gastrointestinal:** No Gastrointestinal Symptoms; Heartburn Indigestion Difficulty Swallowing Nausea Vomiting  
Abdominal Pain Bowel Movement Changes  
Other \_\_\_\_\_

**Genitourinary:** No Genitourinary Symptoms; Blood in Urine Abnormal Bleeding Back Pain Trouble Urinating  
Urinary Frequency Urinary Urgency Painful Urination Incontinence Rash Lesion  
Discharge Vaginal Odor Vaginal Itching  
Other \_\_\_\_\_

**Endocrine:** No Endocrines Symptoms; Increased Hunger Increased Thirst  
Other \_\_\_\_\_

**Menstrual Cycle:** No Menstrual Symptoms; Mood Swings Irritability Tension/Anxiety Depressed Mood  
Breast Pain/ Tenderness Bloating Feeling out of Control/Overwhelmed  
Other \_\_\_\_\_

**Menopausal:** No Menopausal Symptoms; Hot Flashes Night Sweats Vaginal Dryness Impaired Memory  
Impaired Concentration  
Other \_\_\_\_\_

**Sexual:** No Sexual Problems; Decreased Sex Drive Orgasmic Dysfunction Pain with Sex  
Other \_\_\_\_\_

**Psychiatric:** No Psychiatric Problems; Depression Anxiety  
Other \_\_\_\_\_