Harmony Healthcare for Women, LLC ◇ 100 Kings Way E. ◇ Sewell, NJ 08080

PATIENT HISTORY

I. Identifying Information

Today's Date_____

Name_____ Social Security # _____ Date of Birth_____

Present Employment (title/brief description) _____

Marital Status _____ Ethnic Background _____ Religion _____

What is the reason for your visit?

_____

II. Medical History

Blood Type (if known) _____ Have you gained or lost greater than 20 pounds in the last year? ☐ YES ☐ NO

Have you ever had pelvic surgery? ☐ YES ☐ NO

If yes, specify date and type

_____

Do you have or have you ever had (check all that apply):

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Breast Tenderness
- ☐ Cancer? Specify _____ _____
- ☐ Chlamydia
- ☐ Chronic Fatigue
- ☐ Chronic Headaches
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Hair Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Immunization: German Measles
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ German Measles
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Ovarian Cysts
- ☐ Palpitations
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Poor Sense of Smell
- ☐ Rheumatic Fever
- ☐ Skin Changes
- ☐ Seizures
- ☐ Syphillis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginitis # of episodes _____
- ☐ Visual Disturbances
- ☐ Allergies? List: _____ _____ _____

Please specify any other medical condition(s) for which you have been treated:

_____

_____

Within the last year, have you taken any prescription medications? ☐ YES ☐ NO

If yes, list all medications and diagnoses: _____

_____

Within the last year, have you taken any over-the-counter medications on a regular basis? ☐ YES ☐ NO

If yes, list all medications and diagnoses:_____

_____

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____

☐ Cigarettes – number of packs per day ____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify _____

III. Obstetrical and Gynecological History

Age at first period _____ When was your last period? _____

Are your periods regular? ☐ YES ☐ NO

If yes, what is the usual number of days from the beginning of one period to the beginning of the next? _____

If no, how many times per year do you menstruate? _____ What is the usual duration of your period? _____

Do you use ☐ pads or ☐ tampons? How many pads or tampons do you use on your heaviest day? _____

Are cramps present before, during, or after your period? _____ Are cramps: ☐ Mild ☐ Moderate ☐ Severe?

Do you have to take pain medications for cramps? ☐ YES ☐ NO If yes, specify medications_____

Do you bleed or spot between periods? ☐ YES ☐ NO

How many pregnancies (including miscarriages and abortions) have you had?

	When (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required?	How long to conceive?	Baby Born Alive?	Current Partner the Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? ☐ YES ☐ NO

If yes, explain: _____

Date of last Pap Smear _____ Any abnormal pap smears? ☐ YES ☐ NO If yes, give dates:_____

Date of last Mammogram _____ Date of last Bone Scan _____ Do you Douche? ☐ YES ☐ NO

Age at Menopause _____ Are you currently using Hormone Replacement Therapy? ☐ YES ☐ NO

Have you used Hormone Replacement Therapy in the past? ☐ YES ☐ NO

If yes, what is the total amount of time you used these medications? Years _____ Months _____

IV. Contraceptive/Sexual History

Age at first sexual intercourse _____ Is intercourse difficult or painful for you? ☐ YES ☐ NO

What form of contraception do you use now or have you used in the past? Check all that apply:

☐ Pills (name) _____ ☐ IUD (name) _____ ☐ Diaphragm ☐ Withdrawal

☐ Foams/Jellies ☐ Condom ☐ Rhythm ☐ None ☐ Other: _____

For each contraceptive used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have ever been on oral contraceptives (pills), were your periods regular after stopping the pills? ☐ YES ☐ NO

I CERTIFY that the above medical information is true to the best of my knowledge and I give consent to Dr. Martin E. Kanoff and/or his designee for necessary treatment when indicated.

SIGNED _____