CHRISTIANA CARE HEALTH SYSTEM
Center for Uro-Gynecology and Pelvic Surgery

Patient Name: _____ Date of birth: _____ Date: ____/____/_____

Primary Care Physician: _____
Address: _____

Referring Physician: _____
Address: _____

How did you hear about us? (Please circle all that apply): Your doctor Friend Internet

Yellow pages Newspaper Advertisement Other:_____

PAST MEDICAL HISTORY (Please circle all that apply)

High blood pressure:	Yes	No	Hyperthyroid:	Yes	No	COPD:	Yes	No
Heart Disease:	Yes	No	Hypothyroid:	Yes	No	Asthma:	Yes	No
Irregular heartbeat:	Yes	No	Diabetes:	Yes	No	Glaucoma:	Yes	No
Pacemaker:	Yes	No	Liver disease:	Yes	No	Depression:	Yes	No
Stroke/ TIA:	Yes	No	Reflux:	Yes	No	Anxiety:	Yes	No
Kidney failure:	Yes	No	Phlebitis/ Clots:	Yes	No	Bipolar:	Yes	No
Kidney stones:	Yes	No	Hemophilia:	Yes	No	MS:	Yes	No
Interstitial cystitis:	Yes	No	Transfusion:	Yes	No	Vulvodynia:	Yes	No
Seasonal allergies:	Yes	No	Fibromyalgia:	Yes	No	Arthritis:	Yes	No
Irritable Bowel syndrome:	Yes	No						
Cancer:	Yes	No	Type of cancer:	_____				

Other history: _____

SURGERIES (Please list any surgery you may have had and approximate date)

_____ _____

_____ _____

_____ _____

ALLERGIES: (Please list all allergies. If no allergies, please write "None")

_____

SOCIAL HISTORY: (Please circle all that apply)

Tobacco use:	Yes	No	Quit	Alcohol Use:	Yes	No	Quit
Drug Use:	Yes	No	Quit	Domestic Violence:	Yes	No	

FAMILY HISTORY (please circle yes or no and describe who relative is)

Diabetes:	No	Yes _____	Heart Disease:	No	Yes _____
Hypertension:	No	Yes _____	Stroke:	No	Yes _____
Breast cancer:	No	Yes_____	Colon cancer:	No	Yes _____

Other Family History: _____

PAST OBSTETRICAL/GYNECOLOGICAL HISTORY

Was Last pap smear normal (circle) Yes No Date of last pap smear _____

Was last mammogram normal (circle) Yes No Date of last mammogram _____

Deliveries: Date: Vaginal/Cesarean/Forceps/Vacuum Sex of Child Weight

_____

_____

_____