Gynecology Medical History for Minimally Invasive Laser Procedures

Name:_____ ID#_____

Date: ____/____/_____

Phone 1: _____ Phone 2: _____

Primary Care MD _____ Office Phone:_____

Age: _____

Date of birth: _____/_____/_____

Last pelvic exam: ____/_____/_____

Last pap smear ____/_____/_____

Marital or relationship status:
☐ Single ☐ Married ☐ Long-term relationship
☐ Divorced ☐ Widowed

Reason for consultation: _____

Past Ob/GYN surgeries or procedures including mammogram

	Date	Procedure	Surgeon
1.	____/____/_____	_____	_____
2.	____/____/_____	_____	_____
3.	____/____/_____	_____	_____
4.	____/____/_____	_____	_____

Past surgeries or cosmetic procedures (not Ob/Gyn)

	Date	Procedure	Surgeon
1.	____/____/_____	_____	_____
2.	____/____/_____	_____	_____
3.	____/____/_____	_____	_____
4.	____/____/_____	_____	_____

Personal history

1. Do you smoke? ☐ Yes ☐ No If yes, _____ packs per day, from what age_____
2. What is your daily consumption of alcohol? _____
3. Do you have any of allergies? (check all that apply) ☐ medications ☐ latex ☐ food ☐ plants ☐ anesthesia ☐ other_____
4. Do you have any issues with bruising or bleeding? ☐ Yes ☐ No
5. Do you exercise regularly? ☐ Yes ☐ No
6. Have you ever had an issue with your nerves or muscles? (strokes, temporary paralysis, Bell's Palsy nerve injuries, etc. ☐ Yes ☐ No If yes, describe _____
7. Do you need to take antibiotics before procedures such as dental? ☐ Yes ☐ No

8. Do you get fever blisters often? ☐ Yes ☐ No
9. Have you ever been treated for depression or other mental concerns? ☐ Yes ☐ No
10. Do any diseases run in your family? ☐ Yes ☐ No
11. Do you take any of the following?

☐ Antibiotics	☐ Anti-depressants
☐ Anti-coagulants	☐ Aspirin or Ibuprofen
☐ Blood pressure meds	☐ Hormone/contraceptives
☐ Cortisone or steroids	☐ Insulin
☐ NSAIDS	☐ Thyroid medication
☐ Sedatives	☐ Other_____

13. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

Medical History

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

_____

2. Do you have any of the following?

☐ Arthritis	☐ Bleeding disorders	☐ Breathing issues
☐ Any active infection	☐ Bruising	☐ Back pain
☐ Blood clots	☐ Chest pain	☐ Epilepsy or seizures
☐ Cancer	☐ Diabetes	☐ Heart disease
☐ Hepatitis	☐ High blood pressure	☐ Thyroid disease
☐ Herpes simplex	☐ HIV / Aids	☐ Other_____

Menstrual history

1. Age of first period: _____years
2. If your menstrual periods are regular: periods start every: _____days
3. If your menstrual periods are irregular, periods start every:____ to_____ days
4. Duration of bleeding: _____days
5. Duration of bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
7. First day of last menstrual period___/___/____
8. Is pain associated with periods? ☐ Yes ☐ No ☐ occasionally
9. If yes to 8, is it: before menses? ☐ during menses ☐ both ☐

Pregnancy history

10. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
11. Are you breastfeeding? ☐ Yes ☐ No
12. Number of pregnancies: _____ Live births _____ Abortions _____ Miscarriages _____
    C-sections_____
13. Explanation and dates: _____

Contraceptive history

1. What birth control method(s) do you currently use? _____

Sexual history

1. Do you have a sexual partner? ☐ Yes ☐ No ☐ male ☐ female
2. Are there concerns about your sexual activity which you may want to discuss with your doctor? ☐ Yes ☐ No

Please check if you have any of these symptoms

☐ hot flashes
☐ vaginal dryness
☐ urine leakage
  ☐ when coughing?
  ☐ when laughing?
  ☐ when lifting or other activity?
☐ night sweats
☐ spotting after intercourse
☐ pain with intercourse
☐ other_____
_____
_____

3. **Please check if you have any of the following today:**
   ☐ Active urinary infection
   ☐ Active fungal infection

I have answered the questions contained in this questionnaire to the best of my knowledge.
I understand that it is my responsibility to inform my practitioner of my past and current health conditions as it pertains to the treatment I am seeking.

Signature: _____ **Date:** _____

Patient Name / ID: _____ **Date:** _____/_____/_____

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions, the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CIRCLE ONLY ONE LETTER PER QUESTION.

Lubrication

1. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?
    a. 0 – No sexual activity
    b. 1 – Almost never or never
    c. 2 – A few times (less than half the time)
    d. 3 – Sometimes (about half the time)
    e. 4 – Most times (more than half the time)
    f. 5 - Almost always or always

2. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?
    a. 0 – No sexual activity
    b. 1 – Extremely difficult or impossible
    c. 2 – Very difficult
    d. 3 – Difficult
    e. 4 – Slightly difficult
    f. 5 – Not difficult

3. Over the past 4 weeks, how **often** did you maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
    a. 0 – No sexual activity
    b. 1 – Almost never or never
    c. 2 – A few times (less than half the time)
    d. 3 – Sometimes (about half the time)
    e. 4 – Most times (more than half the time)
    f. 5 - Almost always or always

4. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
    a. 0 – No sexual activity
    b. 1 – Extremely difficult or impossible
    c. 2 – Very difficult
    d. 3 – Difficult
    e. 4 – Slightly difficult
    f. 5 – Not difficult

Orgasm

5. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
    a. 0 – No sexual activity
    b. 1 – Almost never or never
    c. 2 – A few times (less than half the time)
    d. 3 – Sometimes (about half the time)
    e. 4 – Most times (more than half the time)
    f. 5 - Almost always or always

6. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?
    a. 0 – No sexual activity
    b. 1 – Extremely difficult or impossible
    c. 2 – Very difficult
    d. 3 – Difficult
    e. 4 – Slightly difficult
    f. 5 – Not difficult

7. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
    a. 0 – No sexual activity
    b. 1 - Very dissatisfied
    c. 2 – Moderately dissatisfied
    d. 3 – About equally satisfied and dissatisfied
    e. 4 – Moderately satisfied
    f. 5 – Very satisfied

Painful Intercourse

8. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?
    a. 0 – Did not attempt intercourse
    b. 1 – Almost always or always
    c. 2 – Most times (more than half the time)
    d. 3 – Sometimes (about half the time)
    e. 4 – A few times (less than half the time)
    f. 5 – Almost never or never

9. Over the past 4 weeks, how **often** did you experience discomfort or pain following vaginal penetration?
    a. 0 – Did not attempt intercourse
    b. 1 – Almost always or always
    c. 2 – Most times (more than half the time)
    d. 3 – Sometimes (about half the time)
    e. 4 – A few times (less than half the time)
    f. 5 – Almost never or never

10. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?
    a. 0 – Did not attempt intercourse
    b. 1 – Very high
    c. 2 – High
    d. 3 – Moderate
    e. 4 – Low
    f. 5 – Very low or none at all

Urine Leakage

11. How often do you leak urine?
    a. 0 – Never
    b. 1 – About once a week or less often
    c. 2 – Two or three times a week
    d. 3 – About once a day
    e. 4 - Several times a day
    f. 5 – All the time

12. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)?
    a. 0 – None
    b. 2 – A small amount
    c. 4 – A moderate amount
    d. 6 – A large amount

13. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

14. When does urine leak? Please circle all that apply.
    a. Never – urine does not leak
    b. Leaks before you can get to the toilet
    c. Leaks when you cough or sneeze
    d. Leaks when you are asleep
    e. Leaks when you are physically active/exercising
    f. Leaks when you have finished urinating and are dressed
    g. Leaks for no obvious reason
    h. Leaks all the time