Jeri Shuster, M.D., P.A.
and Women's Center, Inc.

Jeri Shuster, M.D., Fellow of the American College Obstetricians and Gynecologists
Kathryn Cervi, C.R.N.P., Women's Health Care Nurse Practitioner

Please help us to help you by completing this health history form. We will review together at your first visit. Included is potentially relevant Ob-Gyn, Medical, Surgical, and pertinent family history.

Name: ____

Reason for today's visit: ____

OB HISTORY:
Number of full term pregnancies: _________________
Number of premature deliveries: _________________
Number of miscarriages or terminations: ___________
Number of live births: _____________
Dates of vaginal deliveries: ______________________
Dates of caesarean deliveries: ____________________

GYN HISTORY:
First day of last menstrual period: Month: _______ Day: _______ Year: _______
Age at first menstrual period: _______
Age at last menstrual period (age at menopause): _______
Number of days from start of one period to start of next period (e.g. 28 days): _______
Range of menstrual periods (e.g. cycles occur every 3 weeks to every 6 months): _______
Duration of flow (count from start of spotting until all bleeding/spotting ends: e.g. 7 days): _______

Date of last PAP smear: Month: _______ Day: _______ Year: _______
PAP result: normal / abnormal
Do you have history of testing positive for cervical dysplasia, pre-cancer, cancer, CIN, SIL? Y / N
Have you had colposcopy (looking at cervix with magnifying microscope): Y / N
Do you have a history of HPV? Y / N

Date of last mammogram: Month: _______ Day: _______ Year: _______
Mammogram result: normal / abnormal
Other breast imaging within last 1–2 years: ultrasound / MRI / result:

Date of last DXA bone density scan: Month: _______ Day: _______ Year: _______
Result: Normal / osteopenia (low bone mass) / osteoporosis

Current method of birth control: abstinence / female partner /sub-fertility / condom / diaphragm / oral contraceptive pill / NUVA Ring / Depo Provera / IUD / female sterilization / vasectomy / menopause / other:

Menstrual problem: heavy menses (saturating 1 pad/hr for at least 4 hrs or heavy enough to disrupt normal activities of daily living) / prolonged menses (> 7 days duration) / anemia due to menses / D&C / endometrial biopsy / hysteroscopy / endometrial ablation /menses less than every 3 months / menstrual cramps / premenstrual cramps / PMS / fibroids

Have you been diagnosed with: endometriosis / chronic pelvic pain / pelvic congestion syndrome / uterine fibroids / bicornuate uterus /ovarian cyst / ovarian tumor / vulvodynia (chronic vulva burning or itching)

Do you have a history of infections?
yeast / bacterial vaginosis / trichomonas / pelvic inflammatory disease (PID) / bladder infection / kidney infection / HPV (human papilloma virus) / genital warts / herpes / chlamydia / gonorrhea / HIV AIDS / syphilis

Have you had HPV vaccine (Gardasil / Cervarix): Y / N

Breast problems: cyst / fibrocystic / lump / nipple discharge / pain / needle aspiration / biopsy / pre-cancer / cancer in situ (DCIS) / invasive cancer. If positive for any, please circle Left / Right / Both.

Menopause problems: hot flashes / night sweats / sleep difficulty / fatigue / cognitive or memory difficulty / vaginal dryness / painful intercourse

Bladder problems: urinary frequency / urgency / loss of urine when experiencing urge to void / loss of urine with cough or sneeze / bladder infection / bladder infection after intercourse / kidney stone

SEXUALITY:
Age at onset of sexual activity: _________
Sexual orientation: heterosexual / lesbian / other: _________
Number of lifetime sexual partners: _________
Approximate date of most recent sexual activity: _________
Length of time in current sexual relationship: years / months
Painful sex / low libido / orgasm difficulty/ abuse

Have you ever been diagnosed with cancer: breast / ovary / fallopian tube / uterus / cervix / vagina / vulva / colon / rectum

Family history of cancer: breast / ovary / fallopian tube / colon / pancreas / brain / genetic cancer risk

Family history of deep blood clots of legs / pulmonary embolism / heart disease prior to age 50 / osteoporosis / hip fracture in parent

PAST MEDICAL HISTORY:

Please help us to help you by checking all that apply:

Acne ____________
Alcohol 3 or more/day ____________
Anemia ____________
Anorexia nervosa ____________
Anesthesia problems ____________
Anxiety ____________
Arthritis ____________
Asthma ____________
Auto-immune condition ____________

Barrett's esophagus ____________
Blood disorder ____________
Blood clot (deep) ____________
Blood clot (superficial) ____________
Blood transfusion ____________
Bulimia ____________
Breast condition ____________

Cancer ____________
Cholesterol ____________
Chronic pain ____________
Colon polyp ____________
Date(s) of colonoscopy(ies): ____________________
Colonoscopy result:
normal / polyp / other: ____________
Follow up advised:
1 yr / 5 yrs / 10 yrs / other: ____________
Connective tissue disorder ____________
COPD ____________

Depression ____________
Diabetes Type 1 ____________
Diabetes type 2 ____________
Disability (please note
accommodations that you require) ____________

Diverticulosis ____________
Diverticulitis ____________
Emphysema ____________
ENT condition ____________
Endocrine condition ____________
Eye disorder ____________

Fibromyalgia ____________
Foot condition ____________
Fracture ____________
Fracture from standing height ____________

Gall bladder disease ____________
Gastrointestinal ____________
GERD ____________
Genetic mutation carrier ____________

Irritable bowel syndrome (IBS) ____________

Hair loss ____________
Hair growth (hirsutism) ____________
Hearing impairment ____________
Headache ____________
Heart attack ____________
Heart disease ____________
Heart murmur requiring
antibiotic prior to dental work ____________
Hyperparathyroid
(overactive parathyroid gland) ____________
Hypertension (high blood pressure) ____________
Hyperthyroid
(overactive thyroid, weight loss) ____________
Hypothyroid
(underactive thyroid, weight gain) ____________

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Infectious disease	___________	Pulmonary embolism	___________
		Psychiatric illness	___________
Joint replacement surgery	___________		
		Rheumatoid arthritis	___________
Kidney disease	___________		
Kidney stone	___________	Seasonal allergies	___________
		Seizure disorder	___________
Lupus	___________	Skin condition	___________
		Steroid medication	
Melanoma	___________	for > 3 consecutive months	___________
Musculoskeletal condition	___________	Substance abuse	___________
Migraine with aura	___________		
Migraine without aura	___________	Tobacco use	___________
		Thyroid nodules	___________
		Thyroid condition	___________
Neurological disease	___________		
		Ulcer	___________
Obesity	___________		
Osteoarthritis	___________	Vitamin D deficiency	___________
Osteopenia	___________	Varicose veins	___________
Osteoporosis	___________		

PLEASE LIST ALL SURGICAL PROCEDURES.

Please indicate whether procedure was Left side vs Right side. (If hysterectomy, please indicate whether surgery was laparoscopic, abdominal, vaginal or robotic. Please indicate whether ovary(ies) removed during surgery.)

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

Date: __________ Procedure: ______________________________

Date: __________ Procedure: _____________________________

Date: __________ Procedure: ______________________________

SOCIAL HISTORY:

Marital status: Married / Single / Widowed / Divorced / Separated / Domestic Partner

Occupation: ____

Highest level of education you have completed: high school / 2 yr College / 4 yr college / postgraduate / other:

Exercise: number of hours / week:

Smoking status:

never smoker / former smoker / current every day smoker / current some day smoker / unknown if ever smoked

Alcohol: _______# of drinks in average week.

Street drugs: No / Yes: _______________________

Prescription medications (please include dosage):

________________________ ______________________ ______________________

________________________ ______________________ ______________________

________________________ ______________________ ______________________

Over-the-counter medications: (please include aspirin, vitamins, herbal supplements).

________________________ ______________________ ______________________

________________________ ______________________ ______________________

MEDICATION ALLERGIES:

Name of medication (please include dosage): _______________________

Reaction: anaphylaxis / shortness of breath / swelling / hives / rash / itching / nausea / vomiting / other: _____________

Name of medication (please include dosage): _______________________

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Name of medication (please include dosage): _______________________

Reaction: anaphylaxis / shortness of breath / swelling / hives / rash / itching / nausea / vomiting / other: _____________

Name of medication (please include dosage): _______________________

Reaction: anaphylaxis / shortness of breath / swelling / hives / rash / itching / nausea / vomiting / other: _____________

Are you allergic to peanuts? Yes / No

Reaction: anaphylaxis / shortness of breath / swelling / hives / rash / itching / nausea / vomiting / other: _____________

410.730.5700 (Tel) • 410.964.3231 (Fax) • 11085 Little Patuxent Pkwy, Suite 204 • Columbia, MD 21044-2979
www.jerishustermd.com