Minnesota GYNECOLOGY & AESTHETICS

• 1421 E Wayzata Blvd Suite 200
Wayzata, MN 55391
• 1560 Beam Ave Suite B
Maplewood, MN 55109
952.473.6642 (MNGA)
952.473.2312 FAX
www.MNGAclinic.com

Place Patient Label Here

REVIEW OF SYSTEMS

Please check any problems you are currently having.

1. **General:** ☐ fever ☐ chills ☐ weight loss ☐ weight gain ☐ fatigue ☐ insomnia
2. **Eyes, Ear, Nose & Throat:** ☐ vision changes ☐ glasses or contacts ☐ headache ☐ hearing loss ☐ sinusitis
3. **Cardiovascular:** ☐ swelling of legs ☐ chest pain ☐ dizzy spells ☐ fainting ☐ difficulty breathing with exertion ☐ rapid hart beat ☐ irregular heartbeat
4. **Respiratory:** shortness of breath ☐ wheezing ☐ cough ☐ coughing up blood
5. **Gastrointestinal:** ☐ constipation ☐ diarrhea ☐ bloody stool ☐ nausea ☐ vomiting ☐ indigestion ☐ fecal incontinence ☐ flatulence
6. **Genitourinary:** ☐ burning with urination ☐ night time urination ☐ frequent urination ☐ trouble emptying your bladder leaking urine ☐ blood in urine ☐ infertility
7. **Musculoskeletal:** ☐ muscle weakness ☐ muscle pain ☐ joint pain ☐ back pain
8. **Skin:** ☐ dry ☐ rash ☐ itch ☐ ulcers ☐ pigmented lesions ☐ change in moles
9. **Breasts:** ☐ pain ☐ lump ☐ nipple discharge
10. **Neurologic:** ☐ fainting ☐ seizures ☐ numbness ☐ severe memory problems ☐ migraine ☐ headaches ☐ trouble walking ☐ ringing in ears
11. **Psychiatric:** ☐ anxiety ☐ depression ☐ crying spells ☐ mood swings
12. **Endocrine:** ☐ hair loss ☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst
13. **Hematologic:** ☐ bleeding ☐ bruising ☐ swollen lymph nodes

PERSONAL PAST HISTORY

☐ Anemia	☐ Diets	☐ Lupus
☐ Arthritis	☐ Eating Disorder	☐ Mitral Valve Prolapse
☐ Asthma	☐ Fibroids	☐ Obesity
☐ Blood Clots (legs/Lungs)	☐ Heart Disease	☐ Osteoporosis
☐ Blood Transfusions	☐ Heart Murmur	☐ Pneumonia
☐ Bowel Problems	☐ Hepatitis	☐ Reflux
☐ Broken Bones	☐ Herpes or Genital Warts	☐ Rheumatic Fever
☐ Cancer (location _____)	☐ HIV (known exposure)	☐ Seizures
☐ Chicken Pox	☐ High Blood Pressure	☐ Stroke
☐ Chlamydia or Gonorrhea	☐ High Cholesterol	☐ Syphilis
☐ Depression	☐ Infertility	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Stones	☐ Tuberculosis

SURGICAL HISTORY

List all Surgeries: _____

_____

List all Hospitalizations: _____

_____

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HEALTH

Screenings	Date of last Pap? _____ Last mammogram? _____ Last bone density? _____ Have you ever had abnormal Pap? ☐ yes ☐ no Last Colonsocopy? _____
Exercise	☐ Sedentary (no exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 block, golf) ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)
Diet	Are you dieting? ☐ yes ☐ no Describe _____ Are you on a physician prescribed medical diet? ☐ yes ☐ no Which one? _____ # of meals you eat in an average day? _____ Glasses of water per day? _____
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ None ☐ Energy Drink # of cups or cans a day? _____
Alcohol	Do you drink alcohol? ☐ yes ☐ no # of glasses/cans per week? _____
Tobacco	Do you use tobacco? ☐ yes ☐ no # cigarettes per day? _____ # of years? _____ or # of years quit? _____
Drugs	Do you currently use recreational or street drugs? ☐ yes ☐ no
Vital Stats	Height _____ Current Weight _____ Maximum Weight _____

List your current **Prescription Medications, Herbs, Vitamins**, appetite suppressants, over-the-counter meds

Name the Drug	Strength	Frequency Taken

List all **Allergies:** _____

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FAMILY HISTORY

Does anyone in your family have any of the following (check and list relative)

- ☐ Arthritis (Lupus) _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Ovarian Cancer _____
- ☐ Kidney Disease _____
- ☐ Osteoporosis _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Uterine Cancer _____

Mother: Age _____ If deceased, cause of death and age _____

Father: Age _____ If deceased, cause of death and age _____

OBSTETRICAL HISTORY

List ALL births, ectopics, miscarriages and terminations:

Birth Year	Birth Weight	Baby's Sex	Type of Delivery	Complications

UROGYN HISTORY

Age at onset of menstruation? _____ First day of last menses? _____

Heavy periods, irregularity, spotting, pain, or discharge? _____

Period every_____days? Length of periods? _____

Any changes in your period? _____

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

☐ yes ☐ no _____

Are you currently sexually active? ☐ yes ☐ no Libido issues? _____

What type of contraception are you using? _____ # of lifetime sexual partners? _____

Any hot flashes or sweating at night? ☐ yes ☐ no Insomnia? ☐ yes ☐ no

Any Hair loss? ☐ yes ☐ no Energy/Vitality issues? ☐ yes ☐ no

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ yes ☐ no

Any problems with control of urination? ☐ yes ☐ no _____

Any discomfort or loss of sensation with intercourse? ☐ yes ☐ no _____

Any vaginal dryness, discharge, irritation or odor? ☐ yes ☐ no _____

Ever have kidney infection? ☐ yes ☐ no

Bladder infection? ☐ yes ☐ no