Minimally Invasive Gynecologic Surgery
New Patient Form

Preferred Name: _____ Age: ___
Gender Identity (*female, male, transgender, non-binary, other):* _____
Pronouns (*she/her, he/him, they/them, other):*_____
Reason for Visit: _____

Menstrual History:
Age at first period: ___
First day of last period: ___/___/____
Have you had a hysterectomy? *Y N*
# of days between periods: ____
# of days of bleeding during period: ____
Bleeding between periods? *Y N*
Heavy bleeding during periods? *Y N*
Do you soak through pads/tampons?
Never Sometimes Often
Pain with periods?
Mild Moderate Severe
Do you ever miss school/work due to period pain?
Never Sometimes Often

Menopausal History (*if applicable)*:
Age at final menstrual period: ___
Hormone Therapy (not birth control)? *Y N Past*
Vaginal Estrogen? *Y N Past*
Vaginal bleeding since menopause? *Y N*
Bothersome hot flashes or night sweats? *Y N*
Bothersome vaginal dryness? *Y N*

Sexual History:
Are you sexually active? *Y N Occasionally Never*
When were you last sexually active? _____
Sexual partners? *Male Female Transgender Other*
New partner since last STD test? *Y N*
How long with current partner(s)? _____
History of STD? *Y N*
If yes, which one(s)? _____
Pain with sexual activity? *Y N*
Concerns about sexual function? *Y N*
Do you have a history of sexual trauma? *Y N*
Do you have a history of abuse or neglect? *Y N*
Do you feel safe in your current relationship? *Y N*
Do you have difficulty with pelvic exams? *Y N*

Pap History:
Last pap smear: ___/___/____
History of abnormal pap? *Y N Year:* _____
History of HPV positive pap? *Y N Year*: _____
Treatment for abnormal pap?
Colposcopy Biopsy LEEP Cone Biopsy
Received all 3 Gardasil vaccines? *Y N*

Pregnancy History:
Total number of times pregnant: ___
# of vaginal deliveries: ____
# of cesarean sections: ____
# of miscarriages: ____
# of abortions: ____
# of ectopic pregnancies: ____
Are you interested in future pregnancy? *Y N*
Do you have a history of infertility? *Y N*

Contraceptive History:
Are you using any method to prevent pregnancy?

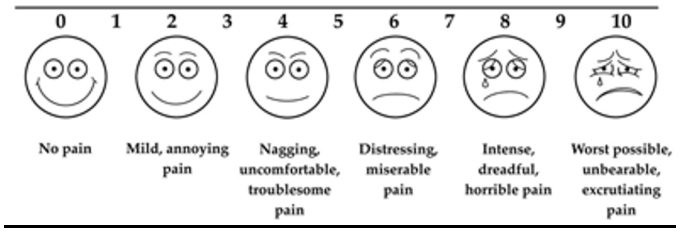
☐ Abstinence	☐ Pills	☐ IUD
☐ Condoms	☐ Patch	☐ Implant
☐ Pull out	☐ Ring	☐ Tubal
☐ Rhythm method	☐ Injection	☐ Hysterectomy
☐ Natural family planning		☐ Vasectomy

Pelvic Imaging (date of last)
Ultrasound: _____
CT Scan: _____
MRI: _____

Pelvic Surgery: *Please list all pelvic surgeries*

Year	*Surgeon/Hospital*	*Procedure*

Pain History:
Please use the pain scale to describe any pelvic pain you are having on a scale of 0 to 10:
Today: ____
During menstrual cycle: ____
During ovulation: ____
During intercourse: ____
During bowel movement: ____
How many days per month do you have pain? ___



Please list any other medical conditions you have:

Please list any other surgeries you have had, including the year (yyyy):

( )	( )
( )	( )
( )	( )
( )	( )

Please list all medications you are currently taking:

Do you have any allergic reactions to drugs?

Medication	***Reaction***

How do you spend your time? What sort of work do you do? _____
_____
Do you live with anyone? *Y N* If so, whom? _____
What are the biggest sources of stress in your life right now? _____
Do you use alcohol? *Y N Formerly*
How many drinks weekly? _____ For how many years? _____
Do you smoke cigarettes? *Y N Formerly*
How many packs daily? _____ For how many years? _____
Do you use any other recreational drugs (including marijuana, vaping)? *Y N Formerly*
If yes, which one(s)? _____
How many times weekly? _____ For how many years? _____

Do **you** have a history of:		Does anyone in your **family** have a history of:	
☐ Endometriosis	☐ Cervical cancer	☐ Endometriosis	☐ Uterine cancer
☐ Fibroids	☐ Uterine cancer	☐ Fibroids	☐ Ovarian cancer
☐ Polyps	☐ Ovarian cancer	☐ Problems with anesthesia	☐ Breast cancer
☐ Prior blood transfusion	☐ Breast cancer	☐ Blood clots in legs or lungs	☐ Colon cancer
☐ Problems with anesthesia			
☐ Blood clots in legs or lungs			

Please mark any of the following symptoms you have experienced in the last 6 months:

☐ Loss of appetite	☐ Abdominal pain	☐ Pain with intercourse
☐ Fatigue	☐ Blood in stool	☐ Pelvic pain
☐ Fever	☐ Constipation	☐ Vaginal bleeding
☐ Unexpected weight change	☐ Diarrhea	☐ Vaginal discharge
☐ Hot flashes	☐ Nausea	☐ Back pain
☐ Night sweats	☐ Vomiting	☐ Skin rash
☐ Nosebleeds	☐ Rectal pain	☐ Headaches
☐ Vision changes	☐ Painful urination	☐ Numbness or tingling
☐ Chest tightness	☐ Urinary frequency	☐ Seizures
☐ Shortness of breath	☐ Urinary urgency	☐ Fainting
☐ Chest pain	☐ Urinary incontinence	☐ Easy bruising
☐ Leg swelling	☐ Blood in urine	☐ Feeling down
☐ Palpitations	☐ Genital sore / ulcer	☐ Feeling anxious