SWAN MEDICAL
PETER CASTILLO MD, FACOG, FPMRS

FEMALE PATIENT HEALTH SUMMARY

Date _____ Name _____ D O B _____

What is the main reason you are here to see the provider today?	1. How long have you experienced each problem? 2. Any prior treatment you had for this?

List any medical problems or health conditions you have:	Year diagnosed:	List any surgeries, procedures or hospitalizations you have had since childhood	Year (if known)

Family History:

Any family history of:	Relationship
( ) High cholesterol	
( ) High blood pressure	
( ) Heart disease	
( ) Diabetes	
( ) Stroke and/or heart attack	
( ) Osteoporosis	
( ) Urinary problems	
( ) Alzheimer's/dementia	
( ) Renal Disease	
( ) Chronic liver disease	
( ) Arthritis	
( ) Cancer (list type)	
( ) Other:	

Activity:
Do you exercise regularly?
( ) 3x a week or more
( ) Occasionally
( ) Rarely

Habits:
( ) I smoke cigarettes or cigars ___ per day
( ) I use caffeine ___ a day
( ) I drink alcoholic beverages ___ per week
Do you use recreational drugs?
( ) Yes: Types/comments: _____

Allergies
List known allergies along with the type of reaction you experience.

Have you ever had any issues with local anesthesia? ( ) Yes ( ) No
Do you have a latex allergy? ( ) Yes ( ) No

Medications

Please list all of the medications you currently take, or any **hormone replacement**. List the dosage and how often you take it.

Medication Name (e.g Advil)	Strength (e.g 100mg)	Dosage (e.g 1 tablet once a day)

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Social History:

( ) I am sexually active OR ( ) I want to be sexually active ( ) I do not want to be sexually active
( ) I have completed my family OR ( ) I have NOT completed my family
( ) My sex life has suffered OR ( ) I have not been able to have an orgasm or it is very difficult

Pertinent Medical/Surgical History:

( ) Breast cancer
( ) Uterine cancer
( ) Ovarian cancer
( ) Polycystic Ovaries (PCOS)
( ) Acne
( ) Excess facial/body hair
( ) Infertility
( ) Endometriosis
( ) Epilepsy or seizures
( ) Fibrocystic breast or breast pain
( ) Uterine fibroids
( ) Irregular or heavy periods
( ) Menstrual migraines
( ) Hysterectomy with removal of ovaries
( ) Partial hysterectomy (uterus only)
( ) Oophorectomy removal of ovaries

Medical Illnesses:

( ) High blood pressure
( ) Heart bypass
( ) High Cholesterol
( ) Hair thinning
( ) Heart disease
( ) Stroke and/or heart attack
( ) Fibromyalgia
( ) Any form of Hepatitis or HIV
( ) Lupus or other autoimmune disease
( ) Frequent blood donation or history of anemia
( ) Arrhythmia or atrial fibrillation
( ) Blood clot and/or a pulmonary embolism
( ) Chronic kidney disease
( ) Cancer (type) : _____
( ) Chronic liver disease
( ) Diabetes
( ) Thyroid disease
( ) Dialysis
( ) Depression/anxiety
( ) Psychiatric disorder
( ) Arthritis

Gynecological History

Menstrual Periods: ( ) Yes ( ) No

- Age of first period: _____
- Last Menstrual Period: _____
- Is your period regular? ( ) Yes, every _____ days; lasts for _____ days
  ( ) No
- Bleed between periods? ( ) Yes ( ) No
- Heavy periods? ( ) Yes ( ) No

Birth Control Method:

( ) Menopause : What age? _____
( ) Hysterectomy: When? _____
Reason? _____
( ) Abdominal
( ) Vaginal
( ) Laparoscopic
Where your ovaries removed? ( ) Yes ( ) No
( ) Left ( ) Right ( ) Both

( ) Tubal ligation
( ) IUD: What type? _____
When was it inserted? _____
( ) Birth Control Pills: What type? _____
( ) Vasectomy
( ) Infertility

Preventative Medical Care:

( ) Last pap smear: _____ Normal: ( ) Yes ( ) No
- History of abnormal pap? ( ) Yes ( ) No

( ) Last mammogram: _____ Normal: ( ) Yes ( ) No

( ) Pelvic Ultrasound in the last 12 months

( ) Bone density in the last 12 months

Obstetrical History

Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

Birth Date	Weight	Type of Delivery	3rd/4th Degree Tears
_____	_____	( ) Vaginal ( ) Vaginal w/ forceps/vacuum ( ) C-section	( ) Yes ( ) No
_____	_____	( ) Vaginal ( ) Vaginal w/ forceps/vacuum ( ) C-section	( ) Yes ( ) No
_____	_____	( ) Vaginal ( ) Vaginal w/ forceps/vacuum ( ) C-section	( ) Yes ( ) No

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FEMALE UROGYNECOLOGIC QUESTIONNAIRE

I urinate every _____ hours during the day.
I get up _____ times to urinate.

Lose urine in spurts with laughing, sneezing or exertion?	( ) Yes ( ) No
Lose urine with strong sense of urgency?	( ) Yes ( ) No
Lose urine with sound, sight, or feel of running water?	( ) Yes ( ) No
Lose urine without any warning (without activity or urgency)?	( ) Yes ( ) No
Wear pads everyday?	( ) Yes ( ) No # pads per day:_____
Difficult to get urine stream started?	( ) Yes ( ) No
Urine stream slow or weak?	( ) Yes ( ) No
Empty bladder completely when urinate?	( ) Yes ( ) No
Pain associated with urination?	( ) Yes ( ) No
Frequent bladder infections?	( ) Yes ( ) No
Feel as if pelvic organs are "falling down"?	( ) Yes ( ) No
Feel bulge at opening of your vagina?	( ) Yes ( ) No

BOWEL FUNCTION QUESTIONNAIRE ( ) Skip this section; I have no problems with my bowel function

I move my bowels ____ times per day or ____ times per week

Difficulty emptying your rectum?	( ) Yes ( ) No
Does it help to press on the inside or outside of vagina?	( ) Yes ( ) No
Lose control of your stool?	( ) Yes ( ) No
Consistency of stool when this happens?	( ) Liquid ( ) Soft ( ) Normal ( ) Hard
Problems controlling gas?	( ) Yes ( ) No
Alternating constipation and diarrhea?	( ) Yes ( ) No
Pain with bowel movements?	( ) Yes ( ) No

COSMETIC GYNECOLOGY CONCERNS ( ) Skip this section; I have no problems with the appearance/function of my genital region

Self-conscious about appearance/function of my genital regions	( ) Yes ( ) No
Unhappy with the way my vagina looks (i.e gaping)	( ) Yes ( ) No
Unhappy with the way my labia looks (irregular, dark, long)	( ) Yes ( ) No
Labia rub or pull on my clothing or during sex	( ) Yes ( ) No
Unhappy with appearance of labia majora	( ) Yes ( ) No
Unable to wear the type of clothing that I want	( ) Yes ( ) No

SEXUAL FUNCTION QUESTIONNAIRE ( ) Skip this section; I have no problems with my sexual functioning

Low desire to participate in sexual activity	( ) Yes ( ) No
Unable to reach orgasm	( ) Yes ( ) No
Significant difficulty reaching orgasm	( ) Yes ( ) No
Difficult time becoming aroused during sexual activity	( ) Yes ( ) No
Do not become sufficiently lubricated during sexual activity	( ) Yes ( ) No
Experienced pain with vaginal penetration	( ) Yes ( ) No
Vagina feels lax/loose during sex	( ) Yes ( ) No
Decreased sensation during sex	( ) Yes ( ) No

HORMONE DEFICIENCY QUALIFYING QUESTIONS

1. Are you over 30 years old? ( ) Yes ( ) No
2. Are you experiencing any of the following?
   - ( ) Loss of energy/frequent exhaustion
   - ( ) Problems with memory, concentration or trouble identifying correct words
   - ( ) Night sweats or sleep problems
   - ( ) Loss of libido or sex drive
   - ( ) Weight management concerns

If you answered yes to any of the above, please complete the following Hormone Assessment Questionnaire

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FEMALE HORMONE ASSESSMENT

Date _____ Name _____ D O B _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never"

Symptoms	**Never** (0)	**Mild** (1)	**Moderate** (2)	**Severe** (3)	**Very Severe** (4)
Sweating (night sweats or increased episodes of sweating)					
Hot flashes					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation					
Sexual problems (change in sexual desire, sexual activity and/or orgasm and satisfaction*)*					
Bladder problems (difficulty in urinating, increasing need to urinate, incontinence					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches and migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					

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CONSENT TO EXAMINATION/PROCEDURES

I _____ understand and consent to examination by Dr. Peter Castillo or designee including procedures vital to the evaluation.

_____ _____

Patient Signature Date