

**Derakhsh Fozouni M.D. Ob/Gyn & Assoc. AMC**

**Patient History Form**

**Gynecology**

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

The reason for your visit? \_\_\_\_\_

Have you seen another physician for this issue? \_\_\_\_\_

How long have you had this issue? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

    If yes, what treatments have you received for it? \_\_\_\_\_

    If yes, have you self treated with any meds or therapies and what? \_\_\_\_\_

Do you have any allergies to any medicine or anesthesia? \_\_\_\_\_

    If yes, what reaction did you have? \_\_\_\_\_

Do you currently have any medical problems? (please list all medical conditions for which you now or have in the past taken medications for )

\_\_\_\_\_  
\_\_\_\_\_

If yes, What medications do you take for it/them?

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_

Have you ever had a blood Transfusion?            Yes or No

    If yes how many units & why? \_\_\_\_\_

Have you had any surgeries in the past? Yes or No

Name of surgery \_\_\_\_\_ what year \_\_\_\_\_

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Have you ever been hospitalized ? Yes or No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

How many times have you been pregnant \_\_\_\_\_

How many children do you have? \_\_\_\_\_

How many live births have you had ? \_\_\_\_\_

How many spontaneous miscarriages have you had? \_\_\_\_\_

How many elective abortions have you had? \_\_\_\_\_

Have you breast fed? Or are you breastfeeding now? If yes, how long have you breastfed for? \_\_\_\_\_

Date of Birth Of your children	When was the baby supposed to be born	Boy or girl	Weight	Vaginal Or C-Section	Did you get an epidural?	Did you have diabetes? High blood pressure? Pre-eclampsia? Seizure or other complications?	Where was the baby born?

The age you had your very first period \_\_\_\_\_

Are your periods every month? Yes or No

How many days between periods? \_\_\_\_\_ How many days do your menses last? \_\_\_\_\_

Date of your last PAP SMEAR \_\_\_\_\_

Have you ever had an abnormal PAP smear? Yes or No

Date of your last mammogram \_\_\_\_\_

Do you perform self breast examination? Yes Or No

First day of your last period \_\_\_\_\_

What is the birth control you're using right now? \_\_\_\_\_

Have you ever had a sexually transmitted infection such as the following: (please circle all that apply) Chlamydia, Gonorrhea, Syphilis, HIV, Hepatitis B or C, Herpes, Trichomonas?

Are you Married Single Divorced Separated

Do you work? Yes No What do you do? \_\_\_\_\_

Do you smoke? Yes No If yes, how many per day? \_\_\_\_\_

How long have you been smoking? \_\_\_\_\_

If you quit, when did you quit smoking? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ how much per day? \_\_\_\_\_

what type of drink? \_\_\_\_\_

Do you use illicit/illegal drugs? \_\_\_\_\_

What is your highest educational level? \_\_\_\_\_

### Family History Complete the information about the health of your family members

Mark with a check mark (✓) all the medical problems that your blood relatives have

Disease	Relation to you
Arthritis/Gout	
Asthma	
Breast Cancer? Ovarian cancer?	
cancer(Other)	
Drug addiction	
Diabetes	
Cardiac issues, strokes,	
High blood pressure	
Kidney disorders	
Tuberculosis	
other	

Will you accept blood transfusion if absolutely necessary? Yes or No

What Ethnicity would you ascribe to yourself? (Please write) \_\_\_\_\_

**Will you be or are you interested in other services that we offer?** (circle all that apply, these are offered at our adjacent office, Lotus Aesthetica)

Laser hair removal (a permanent procedure typically done every 4-6 weeks for 4-6 treatments)

Cellulite removal (procedure typically done every week for 4-6 treatments)

Stretch mark reduction (procedure typically done every 4-6 weeks for 4-6 treatments )

Wrinkles (procedure typically done every 4-6 weeks for 4-6 treatments )

Improvement of surgical and acne scars (procedure typically done every 4-6 weeks for 4-8 treatments )

Melasma, sun spots and/or age spots (procedure typically done every 2-4 weeks for 4-8 treatments )

Vaginal and vulvar rejuvenation (procedure typically done every 4 weeks for 3 treatments )

Body sculpting and permanent fat reduction (procedure typically done every 4-6 weeks for 2-4 treatments )

Flaccid and loose/saggy skin improvement (procedure typically done every week for 4-6 treatments)