Women's Center FOR Continence and Pelvic Medicine

Name: Date:

Adult Data Base

Birthdate: ____________ Birthplace: ____________ Occupation ____________

Medical Problems / Ilnesses

Condition	Yes	No	Condition	Yes	No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Pneumonia/Lung Disease	☐ Yes	☐ No	Eating Disorders	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Arthritis/Joint Pain/Back Problems	☐ Yes	☐ No
Fracture	☐ Yes	☐ No	Lupus / Collagen Vascular Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Reflux/Ulcers/Hiatal Hernia	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Hepatitis/Jaundice/Liver Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Gallbladder Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Colitis/Crohn's Disease	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Anemia/Blood Transfusions	☐ Yes	☐ No
Kidney Infections/Stone	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
STD/HIV/AIDS	☐ Yes	☐ No	Seizures/Convulsions/Epilepsy	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Osteoporosis/Osteopenia	☐ Yes	☐ No	Other	☐ Yes	☐ No

Medications

Medication	*Dosage*	*Frequency*

Allergies

Medications	*Reaction*

Surgeries / Hospitalizations

Socail History/Habits

Habit	Yes	No
Alcohol	☐ Yes	☐ No
Tobacco	☐ Yes	☐ No
Illicit Drugs	☐ Yes	☐ No

Doctors Notes

Obstetrics / Gynecologic History

Age of First Period	________	Number of pregnancies	________
Age of Last Period	________	Number of miscarriages	________
Cycle length	________	Number of Termination	________
Period length	________	Number of ectopic pregnancies	________
Abnormal pap	☐ Yes ☐ No	Number of living children	________
Fibroids	☐ Yes ☐ No	Weight of Heaviest baby	________
Infertility	☐ Yes ☐ No	Bad tear with any delivery	________

Current method of contraception:

Family History

Mother:	Healthy	Other
Father:	Healthy	Other
Grandparents:	Healthy	Other
Siblings:	Healthy	Other
Others:	Healthy	Other

***Note: please list any chronic illnesses or cancer*

Updated 10/17/2007