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***INITIAL VISIT FORM***

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE:** \_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NAME OF PRIMARY CARE PHYSICIAN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LAST GYNECOLOGICAL EXAMINATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR CONSULTATION:**

* ANNUAL EXAMINATION YES\_\_\_\_ NO\_\_\_\_

**DO YOU HAVE ANY COMPLAINTS TO DISCUSS?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ALLERGIES** **NO** **YES** **SPECIFY**

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATIONS |  |  |  |
| LATEX |  |  |  |
| FOODS |  |  |  |
| OTHER |  |  |  |

 **PERSONAL MEDICAL HISTORY NO YES**

|  |  |  |
| --- | --- | --- |
| ANEMIA |  |  |
| ARTHRITIS |  |  |
| ASTHMA |  |  |
| SEASONAL ALLERGIES |  |  |
| CANCER |  |  |
| HYPERTENSION |  |  |
| HIGH CHOLESTEROL |  |  |
| BLEEDING/CLOTTING DISEASE |  |  |
| HEPATITIS |  |  |
| HEART DISEASE |  |  |
| THYROID DISEASE |  |  |
| GASTEROINTESTINAL DISEASE |  |  |
| KIDNEY DISEASE |  |  |
| DEPRESSION |  |  |
| EPILEPSY |  |  |
| LUPUS |  |  |
| OSTEOPOROSIS |  |  |
| TUBERCULOSIS |  |  |
| HIV INFECTION  |  |  |
| EATING DISORDERS |  |  |
| OTHERS PYSCHOLOGICAL PROBLEM |  |  |
| MIGRANE HEADACHE |  |  |
| OTHER |  |  |

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| EVER BEEN HOSPITALIZED? DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REASON:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DATE & PLACE LAST MAMMOGRAM: |
| DATE & PLACE OF LAST PELVIC ULTRASOUND: |
| DATE & PLACE OF LAST BONE DENSITY: |
| LAST COLONOSCOPY DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULT/YEARS OF FOLLOW UP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| LAST SKIN CHECK UP: |
| PRIMARY CARE PHYSICIAN LAST COMPLETE ANNUAL EXAMINATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CURRENT MEDICATIONS**

|  |  |
| --- | --- |
| PRESCRIPTION |  |
| SUPPLEMENTS |  |
| OVER THE COUNTER |  |

**VACCINATIONS DATE**

|  |  |
| --- | --- |
| GARDASIL |  |
| HEPATITIS B |  |
| TETANUS |  |

***PAST SURGICAL HISTORY:***

|  |  |  |
| --- | --- | --- |
| PROCEDURE | YEAR | REASON |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FAMILY HISTORY***

 **PROBLEMS RELATIONSHIP AGE OF DIAGNOSIS**

|  |  |  |
| --- | --- | --- |
| BREAST CANCER |  |  |
| OVARIAN CANCER |  |  |
| COLON CANCER |  |  |
| UTERINE CANCER |  |  |
| PANCREATIC CANCER |  |  |
| MELANOMA |  |  |
| OTHER CANCER |  |  |
| UTERINE FIBROIDS |  |  |
| OSTEOPOROSIS |  |  |
| THYROID DISEASE |  |  |
| DIABETES |  |  |
| HEART DISEASE |  |  |
| HIGH BLOOD PRESSURE |  |  |
| CLOTTING/ BLEEDING PROBLEM |  |  |

**SOCIAL HISTORY**

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEVEL OF DAILY STRESS: LOW\_\_\_ MEDIUM\_\_\_\_\_ HIGH\_\_\_\_\_

DIET (DESCRIBE):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE:**

DO YOU ENGAGE IN REGULAR EXCERCISE? YES\_\_\_\_ NO\_\_\_\_ DESCRIBE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDITATION\_\_\_\_ YOGA\_\_\_\_\_\_

DO YOU SMOKE? YES\_\_\_\_\_ NO\_\_\_ QUIT\_\_\_\_\_\_ # OF CIGARETTES PER DAY? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_\_\_\_

HOW MANY ALCOHOLIC DRINKS PER WEEK? \_\_\_\_\_\_\_\_\_\_\_\_OTHER RECREATIONAL DRUG USE? \_\_\_\_\_\_\_\_\_\_\_\_\_ HISTORY OF SUBSTANCE ABUSE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GYNECOLOGICAL HISTORY:**

* LAST MENSTRUAL CYCLE\_\_\_\_\_\_\_\_\_\_\_\_\_
* DATE/AGE OF FIRST GYNECOLOGICAL EXAMINATION?\_\_\_\_\_\_\_\_
* DO YOU GET REGULAR GYNECOLOGICAL EXAMINATION?

***YES\_\_\_\_ NO\_\_\_ EVERY 6MONTHS\_\_\_\_\_\_\_ EVERY YEAR\_\_\_ OTHER\_\_\_\_\_\_\_***

* AGE OF FIRST MENSTRUAL CYCLE? \_\_\_\_\_\_\_\_\_
* IS YOUR MENSTRUAL CYCLE REGULAR? YES\_\_\_\_ NO\_\_\_\_\_
* HOW MANY DAYS ARE YOU BLEEDING?\_\_\_\_\_\_\_\_\_ HEAVY\_\_\_\_ SPOTTING\_\_\_
* HOW MANYS DAYS IN BETWEEN IS YOUR BLEEDING? \_\_\_\_\_
* WHAT DO YOU USE DURING MENSES?

***SANITARY PADS\_\_\_\_ TAMPONS\_\_\_\_ BOTH\_\_\_\_\_ AVERAGE USE PER DAY\_\_\_\_\_***

* DO YOU HAVE ANY CRAMPING DURING PERIOD?

**YES\_\_\_ NO\_\_\_ MILD\_\_\_ MODERATE\_\_\_\_ SEVERE\_\_\_\_\_**

* DO YOU NEED PAIN MEDICATION (PLEASE LIST):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PAGE 3***

 **NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***HISTORY OF ABNORMAL PAPSMEAR***

|  |
| --- |
| EVER HAD ANY ABNORMAL PAPSMEAR? NO\_\_\_\_ YES\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IF YES: DID YOU HAVE A COLPOSCOPY? DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| EVER HAD ANY TREATMENT OR PROCEDURES ON THE CERVIX? **DATE:****CRYOTHERAPY \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_****LASER TREATMENT \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_****LEEP \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_****MEDICATIONS \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_****CONE BIOPSY \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_** |

***PAST GYNECOLOGICAL SURGERIES***

 **PROCEDURE DATE REASON**

|  |  |  |
| --- | --- | --- |
| MYOMECTOMY |  |  |
| HYSTEROSCOPY |  |  |
| LAPAROSCOPY |  |  |
| HYSTERECTOMY-PARTIAL- TOTAL |  |  |
| OVARIAN CYSTECTOMY |  |  |
| OVARIAN REMOVAL |  |  |
| ENDOMETRIAL ABLATION |  |  |
| TUBAL LIGATION |  |  |
| VULAR SURGERY OR BIOPSY |  |  |
| OTHER |  |  |

***PAST GYNECOLOGICAL DISEASES***

SEXUALLY TRANSMITTED DISEASES: **DATES TREATMENT**

|  |  |  |
| --- | --- | --- |
| CHLAMYDIA |  |  |
| GONORHEEA |  |  |
| HERPES |  |  |
| SYPHILLIS |  |  |
| HEPATITIS B |  |  |
| HEPATITIS C |  |  |
| HIV |  |  |
| TRICHOMONAS |  |  |
| OTHER |  |  |
| HPV |  |  |

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 **NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PROBLEM** **NO**  **YES** **DATE**

|  |  |  |  |
| --- | --- | --- | --- |
| PELVIC INFLAMMATORY DISEASE |  |  |  |
| UTERINE FIBROIDS |  |  |  |
| UTERINE OR CERVICAL POLYPS |  |  |  |
| OVARIAN CYSTS |  |  |  |
| GYNECOLOGICAL CANCER |  |  |  |
| ENDOMETRIOSIS |  |  |  |
| POLYCYSTIC OVARIAN DISEASE |  |  |  |
| CHRONIC PELVIC OR VULVAR PAIN |  |  |  |
| FERTILITY PROBLEMS |  |  |  |
| DES EXPOSURE |  |  |  |
| GENITAL WART |  |  |  |
| RECURRENT VAGINITIS (TYPE OF MEDICATION USED) |  |  |  |

 ***USE OF CONTRACEPTION:***

**BIRTH CONTROL PILLS/TYPE:**

NUMBER OF YEARS\_\_\_\_\_\_\_\_ BRAND USED (LIST ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIDE EFFECTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER METHOD**:

CALENDAR/WITHDRAWAL\_\_\_\_\_ CONDOMS\_\_\_\_ IUD/TYPE/DATE\_\_\_\_\_\_ BILATERAL TUBAL LIGATION\_\_\_\_\_\_\_\_\_\_\_ SPERIMICIDES/ CAPS\_\_\_\_\_ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***HISTORY OF PREGNANCIES***

* TOTAL # OF PREGNANCIES\_\_\_\_\_\_\_\_
* TOTAL NUMBER OF ABORTION \_\_\_ SURGICAL \_\_\_\_ MIFEPREX\_\_\_\_ COMPLICATIONS\_\_\_\_\_\_\_
* NUMBER OF SPONTANEOUS ABORTIONS\_\_\_\_\_\_\_\_\_
* HOW MANY WEEKS IN PREGNANCY\_\_\_\_\_\_\_\_\_\_\_\_\_
* NUMBER OF DELIVERIES\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| DATE |  TYPE |  BIRTH WEIGHT OF INFANT |  COMPLICATIONS |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

* HISTORY OF BREASTFEEDING: YES\_\_\_\_\_ NO\_\_\_\_\_

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 **NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SEXUAL HISTORY***

|  |
| --- |
| AGE OF STARTING SEXUAL LIFE\_\_\_\_\_\_ |
| TOTAL # OF SEXUAL PARTNERS \_\_\_\_\_\_ MALE\_\_\_\_\_\_ FEMALE\_\_\_\_\_\_ |
| CURRENT PARTNERS\_\_\_\_\_\_\_\_ |
| DO YOU USE BARRIER PROTECTION WITH CURRENT PARTNER? YES\_\_\_\_\_ NO\_\_\_\_\_ |
| DO YOU HAVE ANY RISK OF EXPOSURE TO BODY FLUIDS? YES\_\_\_\_\_ NO\_\_\_\_\_ |
| ARE YOU INVOLVED IN VAGINAL\_\_\_\_\_\_ ORAL\_\_\_\_\_\_\_\_ RECTAL INTERCOURSE\_\_\_\_\_\_\_\_ |
| ANY BLEEDING DURING SEX? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ANY HISTORY OF* ABSENCE OF DESIRE FOR SEX\_\_\_\_\_\_
* INABILITY TO ATTAIN OR MAINTAIN LUBRICATION \_\_\_\_
* DELAY OR ABSENCE OF ORGASM\_\_\_\_\_
* GENITAL PAIN ASSOCIATED WITH SEX\_\_\_\_\_
* INVOLUNTARY CONTRACTION OF MUSCLE PREVENTING PENETRATION\_\_\_\_
 |
| HAVE YOU EVER BEEN A VICTIM OF RAPE? \_\_\_\_\_\_ OR SEXUAL ABUSE?\_\_\_\_\_\_\_\_\_\_\_ |
| HISTORY OF ANY FERILITY TREATMENT? PLEASE DESCRIBE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***BREAST HISTORY***

HISTORY OF FIBROCYSTIC BREAST? NO\_\_\_\_\_ YES\_\_\_\_\_\_

HISTORY OF BREAST CANCER? NO\_\_\_\_\_\_ YES\_\_\_\_\_\_\_

* DATE OF DIAGNOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* TREATMENT SURGERY TYPE/PLACE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* RADIATION THERAPY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CHEMOTHERAPY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CHEMOPROPHYLAXUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* CURRENT FOLLOW-UP­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HISTORY OF MASITIS/ABCESS? NO\_\_\_\_ YES\_\_\_\_\_

 HISTORY OF BREAST CYST ASPIRATION? NO\_\_\_\_\_ YES\_\_\_\_\_\_

 DO YOU HAVE BREAST PAIN\_\_\_\_\_\_\_\_\_\_ NIPPLE DISCHARGE\_\_\_\_\_\_\_\_\_ NIPPLE BLEEDING\_\_\_\_\_\_\_\_\_

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 **NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***MENOPAUSAL HISTORY (IF APPLICABLE)***

|  |
| --- |
| LAST MENSTRUAL CYCLE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ARE YOU USING OR EVER USED HORMONE REPLACEMENT THERAPY (INCLUDING BIOIDENTICAL HORMONES)? YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_\_ |
| ARE YOU USING ANY HOMEOPHATIC TREATMENT FOR MENOPAUSAL SYMPTOMS?  YES\_\_\_\_ NO\_\_\_\_ PLEASE LIST­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DO YOU HAVE ANY SYMPTOMS OF * HOT FLASHES\_\_\_\_\_
* INSOMNIA\_\_\_\_\_\_\_\_
* TIREDNESS/LOW ENERGY\_\_\_\_\_
* DEPRESSION/ANXIETY\_\_\_\_\_\_\_
* NIGHT SWEATS\_\_\_\_\_\_\_
* LOW LIBIDO\_\_\_\_\_\_\_\_\_
* VAGINAL DRYNESS\_\_\_\_\_\_\_\_\_\_
* DRY SKIN\_\_\_\_\_\_\_
* CHANGE IN WEIGHT\_\_\_\_\_\_\_\_\_
 |
| DO YOU HAVE ANY URINARY SYMPTOMS?* URGENCY\_\_\_\_
* LEAKAGE\_\_\_\_
* FREQUENCY\_\_\_\_
* RECURRENT URINARY INFECTION\_\_\_\_\_\_
 |

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