LosAngeles Center for Women's Health

Darlene Morrissey, DO, FACOG
Female Pelvic Medicine and Reconstructive Surgery

Patient Name _____ Date: ___ /____ /____
Date of Birth: ___ /____ /____

Primary Care Physician: _____
Address: _____

Referring Physician: _____
Address: _____

How did you hear about us? (Please circle all that apply): Your doctor Friend Internet
Yellow Pages Newspaper Advertisement Other: _____

PAST MEDICAL HISTORY (Please circle all that apply):

High blood pressure:	Y	N	Hyperthyroid:	Y	N	COPD:	Y N
Heart Disease:	Y	N	Hypothyroid:	Y	N	Asthma:	Y N
Irregular Heart Beat:	Y	N	Diabetes:	Y	N	Glaucoma:	Y N
Pacemaker:	Y	N	Liver Disease:	Y	N	Depression:	Y N
Stroke/TIA:	Y	N	Reflux:	Y	N	Anxiety:	Y N
Kidney Failure:	Y	N	Phlebitis/Clots:	Y	N	Bipolar:	Y N
Kidney Stones:	Y	N	Hemophilia:	Y	N	MS:	Y N
Interstitial Cystitis:	Y	N	Transfusion:	Y	N	Vulvodynia:	Y N
Seasonal Allergies:	Y	N	Fibromyalgia:	Y	N	Arthritis:	Y N
IBS:	Y	N					
Cancer:	Y	N	Type of Cancer: _____				

Other history: _____

SURGERIES: (Please list any surgery you may have had and approximate date)

_____ _____
_____ _____
_____ _____

ALLERGIES: (Please list all allergies. If no allergies, please write "NONE")

_____

SOCIAL HISTORY: (Please circle all that apply)

Tobacco use:	Y	N	Quit	Alcohol use:	Y	N	Quit
Drug use:	Y	N	Quit	Domestic Violence:	Y	N	

FAMILY HISTORY: (Please circle Y or N and describe relative)

Diabetes:	N	Y _____	Heart Disease:	N	Y _____	
Hypertension:	N	Y _____	Stroke:	N	Y _____	
Breast Cancer:	N	Y _____	Colon Cancer:	N	Y _____	

Other Family History: _____

PAST OBSTETRICAL/GYNECOLOGICAL HISTORY:

Was last PAP smear normal? Y N Date of last PAP smear _____
Was last mammogram normal? Y N Date of last mammogram _____

Deliveries:	Date	Vaginal/Cesarean/Forceps/Vacuum	Sex of Child	Weight

1513 S. Grand Avenue, Suite 400, Los Angeles, CA 90015 213.742.6400

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REVIEW OF SYSTEMS

Have you had any problems to the following systems in the past month? Circle Y or N

General
- Fatigue Y N
- Fever Y N
- Feel Ill Y N
- Night Sweats Y N
- Weight Gain Y N
- Weight Loss Y N

Ears, Nose, Throat
- Hearing loss Y N
- Runny nose Y N
- Ringing in ears Y N
- Sinus problems Y N
- Sore mouth Y N
- Sore throat Y N

Eyes
- Vision changes Y N

Skin
- Hair loss Y N
- Lesions Y N
- Rash Y N
- Worrisome mole Y N

Allergy/Immunologic
- Hay fever Y N
- HIV exposure Y N
- Hives Y N
- Persistent infections Y N

Breast
- Breast lump Y N

Respiratory
- Cough Y N
- Short of breath while lying down Y N
- Post-nasal drip Y N
- Short of breath Y N
- Wheezing Y N

Cardiovascular
- Chest pain Y N
- Leg pain with motion Y N
- Swelling in legs Y N
- Palpitations Y N
- Swelling elsewhere Y N

Endocrine
- Cold intolerance Y N
- Heat intolerance Y N
- Excessive thirst Y N
- Excess amount of urine Y N
- Night sweats Y N

Hematologic/Lymphatic
- Abnormal bruising Y N
- Excess bleeding Y N
- Swollen lymph glands Y N

Genitourinary
- Burning with urination Y N
- Urinary frequency Y N
- Blood in urine Y N
- Kidney stones Y N

Gynecologic
- Incontinence Y N
- Menstrual irregularity Y N
- Vaginal discharge Y N
- Vaginal dryness Y N
- Vaginal itching Y N
- Vaginal discomfort Y N
- Sexual dysfunction Y N

Gastrointestinal
- Abdominal pain Y N
- Constipation Y N
- Diarrhea Y N
- Difficulty swallowing Y N
- Blood in stool Y N
- Nausea Y N
- Vomiting Y N

Musculoskeletal
- Back pain Y N
- Neck pain Y N
- Joint pain Y N
- Stiffness Y N

Psychology
- Sleep problems Y N
- Depression Y N
- Anxiety Y N
- Suicidal thoughts Y N
- Hallucination Y N

Neurologic
- Headache Y N
- Weakness Y N
- Numbness Y N
- Memory loss Y N
- Tingling Y N
- Tremor Y N

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Name: _____Date of Birth: _____Today's Date _____

INCONTINENCE SEVERITY INDEX (ISI)

Please answer the following two (2) questions:

1. **How often do you experience urinary leakage?** (Please check one)

   _____ Never, I do not leak urine

   _____ Less than once a month

   _____ A few times a month

   _____ A few times a week

   _____ Every day and/or night

2. **How much urine do you lose each time?** (Please check one)

   _____ None, I do not leak urine

   _____ Drops

   _____ Small splashes

   _____ More

Thank you for answering these questions.

For office use only

ISI score _____

ISI category (circle):

None Slight (1-2) Moderate (3-6) Severe (8-9) Very severe (12)

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