THE DIEZ CENTRE FOR WOMEN'S WELLNESS
MAURO E. DIEZ
GYNECOLOGY, INFERTILITY & ENDOSCOPIC SURGERY

PLEASE PRINT

NAME:_____**AGE:**_____ **DOB:** _____ **MARITAL STATUS:**

REFERRED BY OR PRIMARY CARE PROVIDER:_____ **REASON FOR VISIT:**

PHAMACY NAME AND ADDRESS OR PHONE #:

PREFERRED LAB AND IMAGING PLACE: _____

YOUR MEDICAL HISTORY (Please check/circle one or more)

__ANEMIA
__CANCER- what kind of cancer?_____
__OSTEOPENIA
__OSTEOPOROSIS
__EYE PROBLEMS (glaucoma,cataracts)
__THYROID PROBLEMS
__UROLOGICAL PROBLEMS (uterine prolapse)
__HIGH BLOOD PRESSURE
__HIGH CHOLESTEROL
__DIABETES
__ORTHO (chronic back pain, fractures)
__GI ISSUES(crohns/ulcerative colitis, hemorrhoids, acid reflux,polyps)
__PYSCHIATRIC DISORDER (depression,anxiety,bipolar disease)
__DERMATOLOGY DISORDER (eczema/psoriasis, acne)
__RHEUMATOLOGY DISORDER (fibromyalgia,arthritis,osteoarthritis)
__TUBERCULOSIS/POSITIVE PPD
__FREQUENT UTI'S (urinary tract infections)
__NEUROLOGY (strokes, headaches/migraines, seizures,dementia)
__CARDIAC (heart attack, stents, pace maker, heart disease)
__PULMONARY (allergies,asthma,COPD/emphysema,sleep apnea)
__ID(HIV, MRSA, rheumatic fever)
__OTHER

CURRENT MEDICATION MEDICACIÓN ACTUAL	**ALLERGIES TO MEDICATIONS ALERGIAS A MEDICAMENTOS**	**REACTION REACCIÓN**
1)_____	1)_____	_____
2)_____	2)_____	
3)_____	3)_____	_____ **NKDA**
4)_____	4)_____	
5)_____	5)_____	
6)		
7)		

SURGICAL HISTORY (Please print) **HISTORIA QUIRÚRGICA**

PROCEDURE	**REASON**	**YEAR**
1)		
2)		
3)_____	_____	
4)		
5)_____	_____	

SOCIAL HISTORY (Please circle one) **HISTORIA SOCIAL**

DO YOU SMOKE? FUMAS? Yes/No ____ If YES, at what age did you start smoking? Si la respuesta es SÍ, ¿a qué edad comenzó a fumar?
When did you quit smoking?_____ ¿Cuándo dejaste de fumar?
What is your occupation/Job title?_____ Where were you born and raised?_____
Cuál es su ocupación / Título del trabajo? ¿Dónde naciste y creciste?

PAST GYNECOLOGIC HISTORY

1) Date of Last Mammography:_____ Name of radiology place you had your mammogram

2) Date of Last Colonscopy:_____ 3) Date of Dexa Scan (Bone Density Test):

4) Date of last PAP Smear: _____ History of Abnormal Pap Smears? Yes/No

5) HPV test: Positive/Negative 6) HPV Vaccination: completed/not completed (before age 26yrs old)

7) Sexually active: Yes/No

8) History of sexually transmitted disease STD: Yes/No what kind?

9) Currents Birth Control Methods:
(If yes, What Name Brand, IUD Mirena, Paragard, Skyla, Implanon, Pills, Patch, Condoms)

10) Age of 1st period: _____ Yrs Old
Edad del primer período:____
11) First day of your Last period:
Primer día de tu último período:
12) Age of Menopause: ____ Yrs old
Edad de la menopausia: _____
13) Post Menopausal Hormone Use: Yes/No Past user/Current user
Uso de Hormonas menopausia:_____Usuario anterior / Usuario actual
14) Age of Hysterectomy: _____ Yrs Old
Edad de la histerectomía: _____
Total Hysterectomy: Yes/No Reason:_____
Histerectomía total anterior: Sí / No Razón:_____
15) History of Endometriosis: Yes/No
Antecedentes de endometriosis: Sí / No
16) History of Fibroids: Yes/No
Antecedentes de fibromas: Sí / No
18) History of Infertility: Yes/No
Antecedentes de infertilidad: Sí / No
17) History of Ovarian problems: Yes/No
Historial de problemas ovarios: Sí / No
18)History of PCOS: Yes/No
Historial de PCOS: Sí / No

FAMILY'S HEALTH HISTORY HISTORIAL DE SALUD FAMILIAR

Does your family have history of ANY type of cancer? Yes/No If yes, please name who in your family had cancer.
¿Su familia tiene antecedentes de CUALQUIER tipo de cáncer?

	Who	Maternal or Paternal	Age of onset	Age of deceased
BREAST CANCER				
OVARIAN CANCER				
UTERINE CANCER				
CERVICAL CANCER				
COLON CANCER				
OTHER				

OTHER FAMILY HEALTH PROBLEMS OTROS PROBLEMAS DE SALUD FAMILIAR

DIABETES_____ DIABETES _____
HIGH BLOOD PRESSURE_____ ALTA PRESION

OSTEOPOROSIS_____ OSTEOPOROSIS

HEART DISEASE_____ ENFERMEDAD DEL CORAZÓN
OTHER_____ OTRO _____

PAST OBSTETRICAL HISTORY (Please include miscarriages,ectopic, and abortions) **HISTORIA OBSTETRICA PASADA**

Total Pregnancies:_____ Full Term:_____ Premature:_____ Abortions:_____ Miscarriages
Embarazos totales:_____ Término completo:___ Prematuros:____ Abortos:_____ Abortos Espontáneos:
Ectopic:_____ Multiple:_____ Total Living:_____ Ectópico:_____ Múltiple:_Vida Total:

How many vaginal deliveries _____ Cesearan deliveries_____

Cuantos partos vaginales_____ partos por cesárea _____