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Patient Gynecological History
(R. K. Mangal, M.D.)

PLEASE FILL IN ALL THE BLANKS!

Appointment Date: _____

Name: _____ DOB: _____ Age: _____

Phone #'s: Home: _____ Cell: _____ Work: _____

PAST GYNECOLOGICAL HISTORY (Dr. Mangal's patients only):

1. GYN REFERRAL: Who referred you to this clinic? _____
2. REASON for your office visit: _____
3. CHILDREN: Do you plan for children: Yes / No / Not Applicable.
If yes, when? ASAP / after 6 mos./ after 1 yr. / after 2 yrs.
If yes, please bring your partner to the consultation.
4. DELIVERIES: How many deliveries have you had? _____ How many were via C/Section? _____
5. MISCARRIAGES: Have you had any miscarriages? Yes / No If yes, how many? _____ Did you require a D&C? _____ If yes, how many and what year(s)? _____
6. ECTOPIC PREGNANCY: Have you had an ectopic pregnancy? Yes / No If yes, list the year, which fallopian tube was ectopic and method of treatment (Methotrexate or surgery). _____

7. MENSES: First day of last menstrual period. _____ When was the menses before the last one? _____
Age when your first menses started? (i.e.: 11, 12, 13, 14, 15, etc.) _____
How often does your menses occur (from 1st day to 1st day of next menses)? (i.e.: 21-25 days, 25-28 days, 28-35 days, > 35 days). _____
How many days does your menstrual flow last? (i.e., 3-4 days, 5-7 days, 8-10 days, > 10 days) _____
Any blood clots? Yes / No
8. MENSTRUAL CRAMPS: Do you experience any menstrual cramps? Yes / No If yes, how would you grade the pain level on a scale of 1-10? ("1" = no pain at all / "10" = unable to get out of bed, due to the pain) _____
Does the pain radiate to your low back? Yes / No Down the legs? Yes / No
As teenager, were your cramps very painful? Yes / No Did you miss school then? Yes / No
9. PAIN MEDS: What pain medicines have you used within the last year? (i.e.: Tylenol, Advil, Midol, Motrin, Darvocet, Vicodin, etc.) _____ Do pain medicines help? Yes / No / Sometimes

(Continue to next page.)

10. HORMONE THERAPY: Please List chronologically (by estimated dates or by age since your teen-age years to present), any hormonal therapy you were given (i.e., birth control pills, birth control patches, Nuvaring, IUD, Depo-Provera injections, Depo-Lupron, Danazol, etc.).

How long have stopped using contraception of any kind, prior to this visit (i.e., 6 months, 1 year, 2 years, 3 years, > 3 years)? _____

11. BOWEL SYMPTOMS: When your menstrual cycle starts: do your bowel movements become looser? Yes / No
 Any diarrhea? Yes / No Any painful bowel movements? Yes / No Any nausea? Yes / No
 Any vomiting? Yes / No Any abdominal boating? Yes / No Any dizziness? Yes / No
 Any hypoglycemia? Yes / No Any other symptoms? Yes / No

12. BLADDER SYMPTOMS: Do you have to urinate more frequently when your menstrual cycle starts? Yes / No
 Urinary frequency all the time (not just with menses)? Yes / No
 Still feel full after emptying your bladder (urinary urgency)? Yes / No
 Frequent urinary tract infections history? Yes / No
 Frequent vaginal yeast infections during your lifetime? Yes / No

13. DYSPARUNIA: Do you experience any pain during sexual intercourse (especially during deep penetration, like something hitting inside)? Yes / No
 If yes, what % of the time, do you feel this pain? 25% / 50% / 75% / 100%
 Does this happen every time you have sex? Yes / No
 Do you try to avoid certain positions during sex due to pain? Yes / No
 Do you try to avoid sex entirely because of pain? Yes / No

14. PELVIC PAIN: Do you have sharp stabbing pains in the pelvis unrelated to your menses (anytime during the month), which may not last long, but can make you stop in your tracks for a moment? Yes / No
Intensity: Is this pain like needles or pinching? Yes / No; like knife stabbing? Yes / No; Is this pain sometimes severe enough to make you "double over"? Yes / No
Location: Is sharp pain on right side only? Yes / No; Left side only? Yes / No;
 Greater on Left side? Yes / No; Greater on Right side? Yes / No; Equal on both sides? Yes / No
 Do you experience these sharp pains in upper abdomen also? Yes / No If yes, where in the abdomen?
 _____ Do you experience sharp shooting pains in the Vaginal area? Yes / No Do you experience sharp shooting pains in the rectal area? Yes / No
Association: Do the sharp pains in the pelvis and abdomen: 1) increase in frequency after eating food? Yes / No / Sometimes; 2) get better after bowel movements? Yes / No / Sometimes; 3) get worse during menses? Yes / No / Sometimes
 In between these sharp, stabbing pains in the pelvis, do you also experience dull, aching discomfort (soreness) that seems to be present all the time (even when you don't have the sharp pains)? Yes / No / Sometimes
Affect on quality of life: Has pain began to affect activities and quality of life: 1) at Home? Yes / No; 2) Work? Yes / No; 3) School Yes / No / Not Applicable; 4) Other? _____

(Continue to next page.)

15. EMERGENCY ROOM VISITS: Have you had to go to an Emergency room for pelvic pain? Yes / No If yes, list these in chronological order, along with the month and the year. Include which hospital, diagnosis tests performed and their results (ultrasound, MRI, CAT scan, X-rays), and what treatment was given?):
- a. _____
- b. _____
- c. _____
16. GASTROENTEROLOGIST: Were you ever referred to a Gastroenterologist in the past? Yes / No If yes, list these in chronological order, along with the month & year. Include each Doctor's name; Tests performed (i.e.: colonoscopy, proctosigmoidoscopy, barium enema, upper endoscopy, upper GI series X-rays, time capsule bowel motility studies); Diagnosis given (i.e.: IBS, gastritis, gastric ulcers, esophagitis, Crohn's disease, ulcerative colitis, spastic colon, colon polyps, internal hemorrhoids, possible endometriosis of the bowel, etc.); Treatment given (i.e.: high fiber diet, IBS meds, antacids, etc.).
- a. _____
- b. _____
- c. _____
17. UROLOGIST OR GYN-UROLOGIST: Have you ever been referred to an Urologist or Gyn-Urologist? Yes / No If yes, list these in chronological order, along with the month & year: Include each Doctor's name; Tests performed (i.e., cystoscopy, IVP, renal scan, MRI or CAT scan of abdomen, etc.); Diagnosis given (i.e.: Interstitial cystitis, kidney stones, pyelonephritis, hydro ureter, hydronephrosis, congenitally absent kidney, etc.); Treatment or any surgery done (i.e.: medicines to treat I.C., urethral dilation, lithotripsy, ureteral stent placement, etc.).
- a. _____
- b. _____
- c. _____
18. COLON RECTAL SURGEON: Were you ever referred to a Colon Rectal Surgeon in the past? Yes / No If yes, list these in chronological order, along with the month & year: Include each Doctor's name; Tests done, with results (i.e.: proctoscopy, proctosigmoidoscopy, colonoscopy, barium enema, etc.); Diagnosis given (i.e.: bowel endometriosis, any type of fistula, bowel adhesions, colon polyps, bowel obstruction, etc.); Treatment or surgery done (i.e.: small or large bowel resection and re-anastomosis, ileostomy, colostomy, appendectomy, fistula repair, etc.).
- a. _____
- b. _____
- c. _____

(Continue to next page.)

19. PULMONOLOGIST OR THORACIC SURGEON: Were you ever referred to a Pulmonologist or Thoracic Surgeon in the past for spontaneous pneumothorax or endometriosis related chest or shoulder pains? Yes / No

If yes, list these visits in chronological order, along with the month & year: Each Doctor's name; Tests and treatments done.

- a. _____
- b. _____
- c. _____

20. CHRONIC PAIN MANAGEMENT SPECIALIST: Were you ever referred to a chronic Pain Management Specialist in the past? Yes / No If yes, list in chronological order, along with the month & year: Each Doctor's name; Tests and treatments done (which pain meds, nerve stimulator implant, steroid injections, nerve block, etc.)

- a. _____
- b. _____
- c. _____

21. STRESS COUNSELING: Were you ever referred to a Stress counselor/Psychologist/ or Psychiatrist in the past? Yes / No If yes, list these in chronological order, along with the month& year: Each therapists name; Diagnosis (i.e., stress, anxiety, depression, etc.); Treatment given (i.e., exercise, acupuncture, anti-anxiety meds, antidepressant meds, etc.)

- a. _____
- b. _____
- c. _____

22. PRIMARY CARE PHYSICIAN: Do you have a PCP who follows your pelvic and/or abdominal pain? Yes / No If yes, please list the name and phone number. _____

23. GENERAL GYNECOLOGISTS: Have you seen more than one "general" gynecologist in the last 5 years? Yes / No If yes, list these in chronological order with the month & year: Each Doctor's name; Diagnostic Tests done with results (i.e.: pelvic ultrasound, Hysterosalpingogram, etc.); Diagnosis given (i.e.: mild, moderate or severe endometriosis, ectopic pregnancy, PID, fibroids, polyps, intrauterine adhesions, pelvic adhesions, congenital uterine abnormality, etc.); Treatment or surgery done with findings (D & C, hysteroscopy, laparoscopy, laparotomy-open abdominal incision, myomectomy, c-section, tubal ligation, hysterectomy via laparoscopic, robotic, vaginal or abdominal incision):

- a. _____
- b. _____
- c. _____

(Continue to next page.)



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24. STD's: Have you had any sexually transmitted infections? Yes / No
- Chlamydia? What year? _____ Were you hospitalized? Yes / No
- Gonorrhea? What year? _____ Were you hospitalized? Yes / No
- PID (Pelvic Inflammatory Disease)? What year? _____
- Herpes? What year? _____
25. PMS: Do you experience premenstrual symptoms? Yes / No If yes, which ones: mood changes, migraine headaches, abdominal bloating, breast tenderness, other _____
26. PAP SMEAR: When was your last pap smear? _____
- Have you ever had an abnormal pap smear? Yes / No If yes, then did you have treatment? _____ If yes, what was the treatment (i.e.: cryo, LEEP, cone biopsy) and date? _____
27. MAMMOGRAM: If > 35 years old, have you had a mammogram? Yes / No If yes, when? _____
- Result? _____
28. OLD SURGERY RECORDS: If you have had any abdominal surgeries in above Question Number 23, please have copies of those records (Operative reports and any pathology reports from those surgeries), faxed from your doctor to Dr. Mangal's office ASAP. This will assist Dr. Mangal in determining the type of appointment you will need. It may take up to one week to review your records. Thank you for your assistance in getting these records in an expedited manner.

PLEASE FAX THIS FORM BACK TO Dr. MANGAL @ (713) 512-7679!