Medical & Surgical History

This form supports clinical review and does not replace direct discussion with your physician.

GENERAL HEALTH

- [ ] Pregnant or possibly pregnant
- [ ] Breastfeeding
- [ ] Tobacco or nicotine use
- [ ] Alcohol use
- [ ] Cannabis use
- [ ] History of anesthesia complication
- [ ] Personal or family history of blood clots
- [ ] Bleeding or clotting disorder
- [ ] Diabetes
- [ ] High blood pressure
- [ ] Heart disease
- [ ] Lung disease or asthma
- [ ] Kidney or liver disease
- [ ] Seizure or neurologic condition
- [ ] Autoimmune disease
- [ ] Immunosuppression
- [ ] History of MRSA or resistant infection
- [ ] Active infection or current antibiotics
- [ ] Mental health condition requiring treatment

Please explain all checked items, including dates and current status

GYNECOLOGIC & OBSTETRIC HISTORY

Last menstrual period

Menopause status

Number of pregnancies

Number of vaginal deliveries

Cesarean deliveries

Future pregnancy planned?

Gynecologic diagnoses, pelvic-floor symptoms, infections, abnormal bleeding, urinary or bowel symptoms

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PRIOR PROCEDURES

All prior surgeries/procedures, dates, surgeon/facility, and complications

PRIMARY CARE & SPECIALISTS

Primary-care clinician

Telephone

Other treating clinicians and specialties

SIGNATURE

Printed name

Date

Signature (sign after printing or use an approved e-signature workflow)

By signing, I confirm that I reviewed this form and that the information I provided is accurate to the best of my knowledge.