AESTHETIC GYNECOLOGY of DALLAS

**AESTHETIC HISTORY AND PHYSICAL** **Date: _____**

**Patient Name**_____
**Age**_____ **Date of Birth** _____ **Last Menses (1st Day)**_____
**Pregnancies**_____ **Births**____**(Vaginal** ____**Caesarean**____**)** **Miscarriages**____ **Abortions**___
**Address:** _____
_____

**Phone (Home)** _____ **Allergies**: ☐None (**NKA**)
**Phone (Work)** _____ ☐Yes _____
**Phone (Cell)** _____ _____
**Phone (Fax)** _____ _____
**Email** _____ _____

**How did you hear about us? Referred by:** _____

**CHIEF COMPLAINT** (Why you want to see the doctor today?)
_____
_____
_____
_____
_____
_____

**INTERESTED IN AESTHETIC LABIAL AND/OR VAGINAL SURGERY**

_____ I want aesthetic vaginal surgery
_____ My labia are larger/looser than what I want
_____ I do not like the way my labia look
_____ My labia rub, tug, and pull on my clothing
_____ I am unable to wear type of clothing I want
_____ I have had unflattering comments about my genital region
_____ I have had difficult births
_____ My vagina feels too loose inside
_____ I have decreased sensations
_____ I feel pelvic heaviness/pressure
_____ Sex is uncomfortable/unpleasant
_____ I rely on my appearance at work
_____ I am interested in G-Spot treatments

**INTERESTED IN NON-SURGICAL THERMIVA**

☐ To tighten the labia majora
☐ To tighten the vagina
☐ To treat a leaky bladder
☐ To reduce urinary urgency and frequency
☐ To improve vulvar and vaginal moisture
☐ To improve sensitivity of tissues
☐ To improve or achieve orgasms
☐ Reduce painful intercourse

**PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Circle all that apply, Give details**

☐ **Skip this section. I am completely healthy without any conditions mentioned below.**

Are you physically active? Yes No
What type of exercise?_____
Do you now have or have you ever had:
Neurologic problems(seizures, headaches, weakness, paralysis) ? Yes No _____
Psychiatric problems? Depression? Mania? Bipolar? Yes No _____

Head/Ear/Eyes/Nose/Throat Problems? Yes No _____
Thyroid problems or glandular problems? Yes No _____
Cardiac (heart) problems? Palpitations? Chest Pain? Irregular Beat? Yes No _____
Lung Problems? Asthma? Short of Breath? Yes No _____
Breast Problems? Mass? Lumpiness? Discharge? Pain? Yes No _____
Gastrointestinal (stomach) problems (gas, reflux, irritable bowel)? Yes No _____
Kidney or bladder disease? Stones? Infections? Blood in urine? Yes No _____
Liver problems such as hepatitis? Yes No _____
Hematologic problems such as bleeding or anemia? Yes No _____
Diabetes (insulin dependent/oral medication) or low sugar? Yes No _____
Musculoskeletal (bones, joints, muscles) problems? Yes No _____
Circulation problems (varicose veins, thrombosis, blood clots)? Yes No_____
Cancer or Pre Cancerous Conditions Yes No _____
High Blood Pressure or Low Blood Pressure/Fainting Spells Yes No _____
Hernias in the abdomen? Yes No _____
Problems with anesthesia, nausea, anxiety reaction? Yes No_____
STDs (HIV, Gonorrhea, Chlamydia, Hepatitis, Syphilis, Warts) Yes No _____
Other Problems_____
_____
_____

**PAST SURGERIES OR PROCEDURES OR HOSPITALIZATIONS**
**☐NONE**
Please list with date:
_____
_____
_____
_____

**FAMILY HISTORY:** (Please notate immediate relatives and their medical condition)
____ None significant
____ Family _____
_____

**SOCIAL HISTORY:**
Marital status: S M W D

Education:_____

Occupation: ☐Not Working ☐Working Where Working _____
What Occupation _____

Tobacco use: No Yes Other Drugs: No Yes
Alcohol use: No Yes
Abuse: No Yes Describe:_____

**MEDICATIONS:**
**☐NONE ☐SEE ATTACHED LIST**
Please list all current medications and dosages
_____
_____
_____
_____