

Gynecologic History

Patient Name _____ Date of Birth _____ Today's Date _____

Past Medical History *(Please enter the date if you have had any of the following)*

Last Bone Density Scan	Anxiety/Depression	Heart Disease/Heart Murmurs/Rheumatic Fever
Last Cholesterol Test	Arthritis/Joint Pain/Fractures	Hepatitis/Yellow Jaundice
Last Colonoscopy	Asthma/Chronic Lung Disease	High Blood Pressure/Stroke
Last Flu Shot	Bowel or Stomach Problems/Stomach Ulcers	Kidney Infections/Kidney Stones
Last Mammogram	Cancer	Menstrual Problems
Last Pap Smear	Diabetes, Type 1/Type 2	Pneumonia/Tuberculosis
Abnormal Pap Smear	Epilepsy/Seizures or Convulsions	Thyroid Disorder
Anemia/Blood transfusions	Hearing Loss/Visual Disturbance	Venereal Disease

Past Surgical History *(Please enter the date if you have had any of the following operations)*

Abdominal Surgery	Gall Bladder Removal	Other Pelvic Surgery
Appendectomy	Hernia Repair	Ovarian Cyst drainage
Breast Surgery	Hysterectomy	Tubal Ligation
C-Section	Laparoscopy	Other Surgery

Current Medications

Drug Name	Dosage	Drug Name	Dosage

Allergies *(Please list all substances, as well as the reaction you experienced)*

Family Medical History *(Please indicate the relationship of anyone who has had any of the following)*

Illness	Relative	Illness	Relative
Family History of Anesthesia Reaction		Family History of Drinking Problems	
Family History of Blood Clotting Disorder		Family History of Heart Disease	
Family History of Breast Cancer		Family History of High Blood Pressure	
Family History of Colon Cancer		Family History of Ovarian Cancer	
Family History of Diabetes		Family History of Stroke	

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Menstrual History

Age at onset of Periods		Do you have bleeding between periods?	
Menses Duration (# of days of flow)		Cycle interval (# of days between cycles)	
Last Menstrual Period		Flow amount (light, medium, heavy)	
Current method of Birth Control		Age at menopause	

Pregnancy History *(Please indicate the number)*

Total Pregnancies		Full Term Deliveries		Pre-Term Deliveries	
Miscarriages/Abortions		Ectopic Pregnancies		Living Children	

Social History *(Please provide the following information)*

Race	Religion	Marital Status	Occupation	Level of Exercise	Education Level

(Please check all that apply)

Tobacco Use		At risk of STD		Began sexual activity before age 16	
Alcohol/Drug Use		At risk of HIV		Have had more than 5 sexual partners	
History of STD		At risk of domestic abuse		Tested positive for HIV	

Chief Complaint *(Please check that which most closely describes the reason for your visit today)*

Annual Exam		Depression/Emotional Upset		Pelvic Pain	
Abnormal Pap Smear		Infertility		Premarital Exam/Contraceptive Counseling	
Abnormal Periods		Leaking Urine/Prolapsed Organs		Vaginal Infection	
Breast Check		Menopausal Symptoms		Other:	

Review of Symptoms *(Please check if you are currently having problems with any of the following)*

General Wellness		Stomach, Digestion or Bowels		Numbness or Headaches	
Eyes, Ears, Nose or Throat		Urination		Muscles, Bones or Joints	
Breasts		Abnormal or Painful Periods		Weight Loss/Gain, Heat Intolerance, or Hair loss/Growth	
Heart, Chest or Lungs		Skin		Emotions	