Gynecology Health History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Primary MD: _____ Referring MD: _____

Reason for Visit:

Allergies: **____None**

Gynecological History (Answer Yes or No)

1. Did your mother take DES or any other hormones when pregnant with you? Yes ___ No ___
2. Have you ever had a Pap Smear? Yes___ No ___ (if yes, date ___/___/___)
3. Have you ever had an abnormal Pap Smear? Yes ___ No ___ (if yes, date ___/___/___)
4. Are you sexually active? Yes ___ No ___
5. Do you have one partner? Yes ___ No ___ (If no, how many? ____)
6. Is intercourse painful for you? Yes ___ No ___
7. Do you perform monthly self breast exams? Yes ___ No ___
8. Have you ever had a mammogram? Yes ___ No ___ (if yes, last date ___/___/___)
9. Do you exercises on a regular basis? Yes ___ No ___

Preferred Pharmacy:
_____

Address: _____
_____
_____

Phone: _____
Fax: _____

First Date of Last Menstrual Period	**# Days Between Menstrual Periods**	**Length of Menstrual Periods**	**Abnormalities (Circle)** Excessive Bleeding Discharge Pain None

Medications:

Medication	**Dose**	**Directions**	**Reason Taking**	**Prescribed By:**

Contraceptive History:

Type	Date Used
Oral	_____
IUD	_____
Diaphragm	_____
Norplant	_____
Sponge	_____
Spermicide	_____
Condoms	_____
Sterilization	_____
Spouse Sterilization	_____

Hospitalizations: (List operations/serious illnesses that have required hospitalizations. If more than six check here _____)

Date Illness/Operation Complications

_____
_____
_____
_____
_____
_____

Substance Use/Abuse:

Substance	**Y/N**	**Amount**
Alcohol	_____	_____
Tobacco	_____	_____
Caffeine	_____	_____
Drugs	_____	_____

# Pregnancies:	**# Premature:**	**# Miscarriages:**	**# Induced Abortions:**	**# Living Children:**

# Term Births	**DOB**	**Baby's Sex**	**Baby's Weight**	**# Weeks Pregnant**	**Hrs In Labor**	**Type of Delivery**	**Type of Anesthesia**	**Complications Y/N**
1								
2								
3								
4								

Patient Name: **DOB:** **DOS:**

Medical History

Have you or any members of your family had any of the following:

		Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other		
1.	High Cholesterol												
2.	Heart Disease												
3.	Rheumatic Fever												
4.	High Blood Pressure												
5.	Asthma												
6	Tuberculosis												
7.	Diabetes												
8.	Thyroid Problems												
9.	Liver Disease												
10.	Stomach, Bowel or Gall Bladder Problems												
11.	Kidney or Bladder Problems												
12.	AIDS (HIV)												
13.	Hepatitis (type _____)												
14.	Anemia or Blood Disorder												
15.	Blood Transfusion												
16.	Allergies, Sinus Infections												
17.	Breast Problem												
18.	Cancer Breast												
19.	Cancer Cervix												
20.	Cancer Uterus or other female organs												
21.	Cancer other (Type _____)												
22.	Infertility												
23.	Female or Sexual Problems												
24.	Chlamydia												
25.	Gonorrhea												
26.	Herpes (HSV)												
27.	Syphilis												
28.	Birth Defects or Inherited diseases												
29.	Sexual Abuse or Domestic Violence												
30.	Other Medical Problems not list above												
31.	NO KNOWN MEDICAL PROBLEMS												

Please provide detailed information on positive findings from the Medical History list above. Use the reference numbers to identify.

A Physician Signature verifies that this form was reviewed and necessary information pertinent to problems have been noted in the patient's chart note.

Physician's Signature **Date Reviewed:**