Department of Obstetrics & Gynecology

Name: ____________________

SSN: ____________________

Date of Birth: ____________________ Age: ____________ Date: ____________________

Name of Your Family Physician: ____________________ Referring Physician: ____________

Main Reason for Your Visit: ____

____

GYNECOLOGIC HISTORY

Menstrual History

When was the first day of your last normal menstrual period? ____/____/____

How old were you when you first began to have periods? ________

How many days apart are your normal periods? ______ days

(from the first day of one period to the first day of the next period)

How many days does your normal period last? ______ days

Do you have heavy periods? ☐Yes ☐No

painful periods? ☐Yes ☐No

bleeding or spotting in between periods? ☐Yes ☐No

Have you stopped having periods, and if "YES", since what age? ☐Yes ☐No ____________

Are you currently on hormone therapy, and if "YES", what kind? ☐Yes ☐No ____________

Have you ever taken hormone therapy, and if "YES", what kind? ☐Yes ☐No ____________

Pap Smear History

When was your last pap smear? ____________________ Was it normal? ☐Yes ☐No

If "NO", please explain. ____

Have you ever had an abnormal Pap smear? ☐Yes ☐No

If "YES", when? Date ____________________ Result ____________________

Describe action taken: ☐ Repeat Pap only ☐ Colposcopy ☐ Biopsy ☐ Treatment with: ____________

Sexual History

☐ I would prefer to talk with my doctor about my sexual history.

How old were you when you first had sex? _____

Are you currently sexually active? ☐ Yes ☐ No

Do you prefer: ☐ Men (heterosexual) ☐ Women (homosexual) ☐ Both (bisexual)

How many partners have you had in your lifetime? _____ Men: _____ Women: _____

Do you currently have sex with only one person? If "YES", for how long? ______ ☐ Yes ☐ No

Have you ever had any sexually transmitted infections? If "YES", please circle which ones: ☐ Yes ☐ No

Chlamydia Gonorrhea PID (pelvic inflammatory disease) Trichomonas Herpes HIV Genital Warts

Do you want to be tested for any sexually transmitted infections? ☐ Yes ☐ No

Do you have any pain or discomfort during sex? ☐ Yes ☐ No

Do you have any other concerns about sex? ☐ Yes ☐ No

Please Complete Reverse Side

Contraceptive History

What is your current method of birth control? ______________________ For how long? __________

What methods have you used in the past? ______________________ For how long? __________

Are you interested in a new method? ______________________ ☐ Yes ☐ No

Breast Health History

Do you examine your breasts each month? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Have you ever had a breast ultrasound? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Have you ever had a breast cyst aspiration or breast biopsy? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Bone Health History

Have you ever had a bone density test? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Have you ever taken steroid medications? If "YES", how long did you take them? ________ ☐ Yes ☐ No

Have you ever had any bone fractures? If "YES", what kind and when? ____________ ☐ Yes ☐ No

Have you had any loss of height, i.e., gotten shorter? ☐ Yes ☐ No

Other Preventive Care

Have you ever had a colonoscopy, flexible sigmoidoscopy or barium enema? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Have you ever had your cholesterol tested? ☐ Yes ☐ No

If "YES", when? ____________ What was the result? ____________

Are your vaccinations up to date? ☐ Don't know ☐ Yes ☐ No

OBSTETRICAL HISTORY

Please include any miscarriages, abortions or ectopic pregnancies

	Year	Length of Pregnancy	Mode of Delivery (Vaginal or C-section)	Complications	Birth Wt.	Sex
1						
2						
3						
4						
5						
6						

PAST MEDICAL HISTORY

Please circle any medical condition that you have, or have had in the past.

- Asthma
- Bleeding or Blood-Clotting Disorder
- Blood clot in leg or lung
- Cancer - What type? _______
- Diabetes
- Eating Disorder
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Infections
- Osteoporosis
- Psychiatric Disorder
- Seizures
- Stroke
- Thyroid Disease

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you have heart valve disease (i.e. mitral valve prolapse, aortic stenosis)? ☐ Yes ☐ No

If "YES", do you take antibiotics for dental or surgical procedures? ☐ Yes ☐ No

Please list any other medical conditions or hospitalizations you have: ____________________

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PAST SURGICAL HISTORY

Please list any operations that you have had with dates.

1. ______________________ 4. ______________________ 7. ______________________
2. ______________________ 5. ______________________ 8. ______________________
3. ______________________ 6. ______________________ 9. ______________________

MEDICATIONS

Please list current medications, including over-the-counter medications and herbal/natural products.

1. ______________________ 4. ______________________ 7. ______________________
2. ______________________ 5. ______________________ 8. ______________________
3. ______________________ 6. ______________________ 9. ______________________

MEDICATION ALLERGIES

Please list any allergies to medications, latex and other agents.

1. ______________________ 3. ______________________ 5. ______________________
2. ______________________ 4. ______________________ 6. ______________________

SOCIAL HISTORY

Occupation: ______________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you smoke now? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No ☐Yes ☐No

If "YES", how many packs per day and for how many years? _______ packs/day _______ years

Do you drink alcohol? If "YES", how much and how often? ______________________ ☐Yes ☐No

Do you use recreational drugs? If "YES", what kind? ______________________ ☐Yes ☐No

Do you drink caffeine (coffee, tea, sodas)? If "YES", how many cups/drinks per day? _______ ☐Yes ☐No

Do you feel unsafe where you live because of a threat of violence against you by your partner? ☐Yes ☐No

Have you ever been threatened, hit, slapped, or kicked by anyone you know? ☐Yes ☐No

Has anyone forced you to perform any sexual act against your will? ☐Yes ☐No

Do you always wear your seatbelt in the car? ☐Yes ☐No

Do you exercise regularly? If "YES", what kind and how often? ______________________ ☐Yes ☐No

FAMILY HISTORY AND GENETIC SCREENING

Please circle any medical condition that affects a member of your family.

Adopted, history unknown
Alzheimer's Dementia
Birth defects/mental retardation
Bleeding or Blood-clotting disorder
Blood clot in leg/arm
Blood clot to lung
Diabetes

Cancers: Breast
Colon (large bowel)
Endometrial (uterine)
Other:____________
Ovary

Heart Disease
High Blood Pressure
High Cholesterol
Osteoporosis
Psychiatric Disorder
Stroke
Thyroid Disease

Please list any medical conditions that affect the following family members:

Relative	Age	Living or Deceased	Medical Conditions
Mother			
Father			
Siblings			
Children			
Other			

Please Complete Reverse Side

REVIEW OF SYMPTOMS		
Please circle those symptoms that you currently experience or have experienced in the last two weeks.		
fever	headaches	hearing loss
visual change	leg swelling	heart palpitations
chest pain	coughing up blood	wheezing
persistent cough	stomach ulcer	sinus infections
abdominal pain	dark stool	constipation
diarrhea	frequent urination	bright red blood on stool
burning with urination	uncontrolled loss of urine	sense of urge with urination
blood with urination	vaginal discharge	frequent urination at night
kidney stones	muscle pain	vaginal dryness
muscle weakness	new or growing mole	joint pain
skin rash	breast pain	nonhealing sore
breast lump	loss of consciousness	nipple discharge
dizziness	crying spells	seizure
anxiety	hot flashes/night sweats	depression
heat/cold intolerance	increased facial hair growth	acne
hair loss	weight loss or gain	unusual bruising
fatigue	unusual bleeding (i.e., nose, gums)	
shortness of breath at rest, with activity, or lying down		

What other questions or concerns would you like to discuss with your doctor?

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Form Completed By: ______________________ Date: ______________