GYNECOLOGIC HISTORY

NAME _____ DATE _____

GENERAL MEDICAL HISTORY

Do you have a primary care physician? _____ Who? _____
Do you eat a well-balanced diet? YES NO
Do you include atleast 3 servings a day of dairy products? YES NO
Do you exercise regularly? YES NO WHAT? _____
Do you have medication allergies? YES NO WHAT? _____
Do you have any other allergies? YES NO WHAT? _____
Do you smoke? YES NO HOW MUCH? _____
Do you use alcohol? YES NO HOW MUCH? _____
Do you use any "street drugs" including intravenous use? YES NO
Have you ever had a blood transfusion? YES NO When?
Do you take any medication regularly (includes aspirin)?
If yes, what? _____
_____
Do you take any herbal supplements? If yes, what? _____

Circle any of the following you have had problems with:

Asthma	Thyroid	Sickle Cell Disease	Sexually Transmitted Disease
Migraine	Heart	Blood Pressure	Chlamydia
Diabetes	Lungs	Blood Disorder	Trichomonas
Cholesterol	Eyes	Liver (Jaundice or Hepatitis)	Syphilis
Stroke	Breasts	Cancer (of what)?	"PID"
PMS	Kidney	Repeated Yeast Infections	Venereal Warts
	Bladder	Gonorrhea	Herpes

GYNECOLOGIC HISTORY

When was your last pap smear? _____
Was your pap ever abnormal? YES NO When? _____
Do you do self breast exams regularly? YES NO Mammogram? When? ___
Age periods started _____ Are they regular? YES NO Every____days?
Periods last _____ days? Cramps? _____ Disabling? _____
First date of your last period? _____ Was it normal for you? _____
Have you had sexual intercourse? _____ Do you have pain with intercourse? ____
Have you ever been sexually abused? _____

Your Initials _____

CONTRACEPTIVE USE HISOTRY

Circle a contraceptive you have used and give approximate dates of use:

Rhythm or symptothermal _____ Oral "pill" _____ Norplant _____
Foam, Sponge, or Insert _____ IUD _____ Depo-Provera _____
Diaphragm or Condom _____ Tubal Ligation _____ Implanon _____
Vasectomy _____

Are you using any birth control now? _____ What? _____
If none, why not? _____
Have you had any problems with a birth control method? If yes, please explain._____

PREGNANCY HISTORY

Is there a chance that you are pregnant now? YES NO

Please list your pregnancies in order, including any losses or abortions:

YEAR WEEKS COMPLETED TYPE OF DELIVERY COMPLICATIONS WEIGHT OF INFANT

_____
_____
_____
_____
_____

SURGICAL HISTORY Please list type of operation, year it was done, and reason:

Have you or a family member ever had a surgical or anesthetic complication?
Explain:

Your Initials _____

FAMILY HISTORY Circle those your blood relatives (parents, grandparents, brothers, sisters) have had:

Diabetes	**High Blood Pressure**	**Any other cancer, including prostate:**
Osteoporosis	**High Cholesterol**	_____
Stroke	**Heart Disease**	_____
Breast Cancer		
Ovarian Cancer		

Do you ever lose urine involuntarily?	**YES**	**NO**
When you cough or sneeze?	**YES**	**NO**
With vigorous exercise?	**YES**	**NO**
If you have a full bladder?	**YES**	**NO**
Do you do "Kegel" exercises? How often?	**YES**	**NO** _____

Who may we contact in case of an emergency? Please list name, phone number, and relation to you:

Thank you for taking the time to fill out this form. It helps us to give you better care, which is our primary goal.

Is there someone you would like to release information to?

Please be aware that without your express consent we do not release any information to ANYONE. This includes husband, mother, father, etc. (even if you are a minor).

What specific concerns would you like to discuss in our office today?

Your Signature _____