Pacific Women's Center

GYN History

Patient Name_____ Date of Birth____/___/_____ Today's Date ___/___/_____

GYN History

Have you ever had or do you currently have any of the following?

Breast Lump	Abnormal Vaginal Bleeding	Gonorrhea	Hot Flashes
Breast Cancer	Abnormal Pap Smear	Herpes	HPV
Breast surgery	Extreme Menstrual Pain	Painful Intercourse	Infertlity
Cervical Cance	Bleeding between Periods	Urinary Incontinence	Nipple Discharge
Chlamydia	DES Exposure	Yeast Infections-Frequent	Ovarian Cysts
Colposcopy	Fibroids	Pelvic Inflammatory Disease	Ovarian Cancer
Cryosurgery	Genital Warts	Irregular Periods/Bleeding	Uterine Cancer

At what age did you become sexually active? _____ Total number of partners: _____

Pregnancy History

Please descibe any pregnancies you have had:

Preg _____ # full term _____ # miscarriage _____ # abortions _____

Past Pregnancies

Date	Length of Preg.	Type of Delivery	Sex	Living	Weight
__/__/____	____ mo	normal / C-Sect	M / F	Y / N	____lbs ____oz
__/__/____	____ mo	normal / C-Sect	M / F	Y / N	____lbs ____oz
__/__/____	____ mo	normal / C-Sect	M / F	Y / N	____lbs ____oz
__/__/____	____ mo	normal / C-Sect	M / F	Y / N	____lbs ____oz

Were there any complications associated with any of your pregnancies? _____

Are you currently pregnant? _____ Are you trying to become pregnant? _____

Do you need birth control or contraceptive advice? Y / N What method of birth control do you use? _____

What other methods of contraception have you used? _____

Menstrual History

Blood Sugar Fasting _____

Breast Self Exam _____

Cholesterol Test _____

Colonoscopy _____

Dexascan (Bone Density) _____

What age were you when you had your first period? _____

How often does your period occur? _____

Is your period regular? _____

At what age did you become sexually active? _____

Health Exams & Procedures

	DATE	Results
Fecal Occult Blood Test		
Mammogram		
Pap Smear		
Ultrasound		
Gaurdasil Vaccine		

When was the first day of your last period? _____

How long does your period last? _____

What age where you at menopause? _____

Total number of partners: _____

Reason for visit

How is your general health? Excellent_____ Good_____ Fair_____ Poor_____

What brings you to the office today? _____

_____

Do you have any other concerns you would like to address? _____

Pacific Women's Center
600 Corporate Drive, Suite 210
Ladera Ranch, CA 92694

Phone: 949.364.3940
Fax: 949.364.3931

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Patient Name_____ Date of Birth____/___/_____ Today's Date __/___/___

Column1 Column2 Column3 Column4

Current Medications

What medications are you currently taking?

Name_____Dosage_____Freq_____
Name_____Dosage_____Freq_____
Name_____Dosage_____Freq_____
Name_____Dosage_____Freq_____
Name_____Dosage_____Freq_____

Allergies

Are you allergic to any of the following?

Adhesive Antiot Latex
Barbiturates Aspiri Iodine
Codeine Sulf Local Anesthetics

Do you have any other allergies?

Type _____ Reaction _____

Past Medical History

Alcoholism	Back Problems	Ear Problems	Hepatitis– A, B or C	Measle	Skin Disorder
Allergies	Bleeding Disorder	Eating Disorder	High Blood pressure	Migraine	Stomach Ulcer
Anemia	Blood Disease	Epilepsy	High Cholesterol	Osteopc	Substance Abuse
Anxiety Disorder	Blood Transfusion	Glaucoma	Joint Disorder	Pneumc	Thyroid Disorder
Arthritis	Cancer	Gout	Kidney Dosorder	Polio	Tuberculosis
Asthma	Diabetes	Heart Disease	Liver Disorder	Stroke	Venereal Disease
AIDS/HIV	Depression	Heart Problems	Lung Disease	Rheumatic Fever	

Hospitalizations & Surgeries

Reason_____Date_____
Reason_____Date_____
Reason_____Date_____
Reason_____Date_____
Reason_____Date_____

Lifestyle Factors

Are you sexually active?

Yes or No # of partners in past year_____

Do you wish to be tested for STD's?

Yes or No

Family History

Has anyone in your family ever had the following conditions?

Alcoholism	Cancer	Joint Disorder
Allergies	Depression	Kidney Disease
Alzheimers	Diabetes	Liver Disorder
Anemia	Epilepsy	Lung Disease
Anxiety	Genetic Disorder	Migraines
Arthritis	Glaucoma	Psychiatric Disorders
Asthma	Heart Disease	Osteoporosis
AIDS/HIV	Hepatitis	Stroke
Bleeding Disorder	High Cholesterol	Substance Abuse
Blood Disorder	High Blood Pressure	Thyroid Disorder

Details:_____
_____

Has anyone ever physically hurt you?

Yes or No

Have you ever smoked?

Yes or No # of years ____ # packs/day _____

Do you smoke now?

Yes or No # packs/day # times/week _____

Do you use recreational drugs?

Yes or No Types? _____

How much alcohol do you drink pe_____
How much caffeine do you drink p_____
How often do you exercise? _____

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