Health History

Patient Name: ____________ Date of Birth: ______________ Today's Date: ____________

Your PCP/Family Physician:___________________________ Date of Last Visit: ________________

Reason for Today's Visit:

☐ I need an annual gynecological exam.

☐ I am having a specific problem. Please describe.

____

Current method of contraception (oral, IUD, tubal, vasectomy, other): ______________________________

Dates of Your Last:

Mammogram: ___________________________ Pap Smear: ___________________________

Bone Density:___________________________ Colonoscopy:___________________________

Medical History:

☐ *No Pertinent History* ☐ Asthma ☐ Blood Clotting Disorder

☐ Breast Cancer ☐ COPD ☐ Diabetes Type I

☐ Diabetes Type II ☐ GI Cancer ☐ Glaucoma

☐ Heart Disease ☐ High Cholesterol ☐ High Blood Pressure

☐ Infertility ☐ Irritable Bowel Syndrome ☐ Lupus

☐ Migraines ☐ Kidney Stones ☐ Ovarian Cancer

☐ Rec Bladder Infection ☐ Seizures ☐ Sleep Apnea

☐ Stroke ☐ Thyroid Disorder

Other: ____

Surgical History:

☐ *No Pertinent History* ☐ Appendix Removal ☐ Back Surgery ☐ Breast Implant

☐ Breast Reduction ☐ Colonoscopy ☐ Cystocele Repair ☐ Gallbladder Removal

☐ Hip Replacement ☐ Hysterectomy ☐ Lumpectomy ☐ Knee Replacement

☐ Mastectomy ☐ Rectocele Repair

Other: ____

Medications: List all medications you are taking (including Aspirin) and frequency of each:

____

____

____

____

Allergies: List any medications (including x-ray dye) that you have had a reaction to:

☐ None ☐ Contrast Dye Other: ____

Family History:

Breast Cancer: Y N - Paternal Maternal - Age at Diagnosis: _____

Colon Cancer: Y N - Paternal Maternal - Age at Diagnosis: _____
Ovarian Cancer: Y N - Paternal Maternal - Age at Diagnosis: _____
Other: ____

Social History:

Tobacco: ☐ Never ☐ Former ☐ Current Some Days ☐ Current Every Day
Alcohol: ☐ Never ☐ Former ☐ Current Some Days ☐ Current Every Day
Recreational Drugs: ☐ Never ☐ Former ☐ Current Some Days ☐ Current Every Day

Reproductive History:

Number of pregnancies ___________________

List outcome of each pregnancy, including dates delivered, vaginal or C-section, sex and weight of baby, and any complications with the pregnancy:

1.____

2.____

3.____

4.____

5.____

Date of last menstrual period_____________________________

Are your cycles light, moderate or heavy?____________________________

Are your cycles regular or irregular?_________________________________

Too frequent or too few?__________________

Number of weeks between cycles___________________________________

Do you suffer from painful cycles? No Yes