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**GYNECOLOGY HEALTH HISTORY**

Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

**Current Medications** \_\_\_ None

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**Medication Allergies:** \_\_\_ None

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**Medical History** (check all that apply)

Have you or any member of your family had:

Self / Family Self / Family

- High Cholesterol………………...S / F - Blood Transfusion…………………………S / F

- Heart Disease……………………S / F - Allergies…………………………………...S / F

- Rheumatic Fever…………………S / F - Breast Problems…………………………...S / F

- High Blood Pressure…………….S / F - Cancer……………………………………..S / F

- Asthma…………………………...S / F - Infertility…………………………………..S / F

- Tuberculosis……………………...S / F - Female or Sexual Problems……………….S / F

- Diabetes………………………….S / F - Chlamydia…………………………………S / F

- Thyroid Problems………………..S / F - Gonorrhea…………………………………S / F

- Liver Disease…………………….S / F - Herpes……………………………………..S / F

- Stomach, Bowel or………………S / F - Syphilis……………………………………S / F

Gallbladder Problems……………S / F - Birth Defects or Inherited Diseases……….S / F

- Kidney or Bladder Disorder……..S / F - Sexual Abuse or Domestic Violence………S / F

- AIDS (HIV)...................................S / F - Other Medical Problems:.............................S / F

- Hepatitis (type\_\_\_\_\_\_\_\_\_)............S / F \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Anemia or Blood Disorder………S / F - No Known Medical Problems…………….S / F

**Pregnancy History:**

| # of Pregnancies:  \_\_\_\_\_\_ | # of Premature Births:  \_\_\_\_\_\_ | # of Miscarriages:  \_\_\_\_\_\_ | # of Induced Abortions  \_\_\_\_\_\_ | # of Living Children:  \_\_\_\_\_\_ |
| --- | --- | --- | --- | --- |

| # of  Term Births | Born  Month/Year | Baby’s  Sex  F/M | Weight  At  Birth | Weeks Pregnant  Term-40wks | Hours  In  Labor | Type  of  Delivery | Type  of  Anesthesia | Complications?  yes/no |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | / |  | lbs. oz. |  |  |  |  |  |
| 2 | / |  | lbs. oz. |  |  |  |  |  |
| 3 | / |  | lbs. oz. |  |  |  |  |  |
| 4 | / |  | lbs. oz. |  |  |  |  |  |
| 5 | / |  | lbs. oz. |  |  |  |  |  |

**Menstrual History**

First Day of Last Menstrual Period \_\_\_\_/\_\_\_\_/\_\_\_\_

| Menarche  (Age at 1st Period) | Interval  (# of days between periods) | Length of Period |
| --- | --- | --- |
| \_\_\_\_\_\_Years | \_\_\_\_\_\_Days | \_\_\_\_\_\_Days |

Abnormalities: \_\_\_\_\_\_Excessive Bleeding \_\_\_\_\_\_Discharge \_\_\_\_\_\_Pain \_\_\_\_\_\_None

**Lifestyle**

Yes / No

Did your mother take DES or any hormones when pregnant with you?...............................Y / N

Have you ever had a Pap test? If yes: Date of your last Pap test? \_\_\_/\_\_\_/\_\_\_

Have you ever had abnormal Pap test results?......................................................................Y / N

Are you sexually active?.......................................................................................................Y / N

Do you have one partner or many partners?.........................................................................Y / N

Is intercourse painful for you?..............................................................................................Y / N

Do you do a monthly self breast exam?................................................................................Y / N

Have you ever had a mammogram?......................................................................................Y / N

Do you exercise on a regular basis?......................................................................................Y / N

**Hospitalizations** (list all hospitalizations and or Surgeries)

Month / Year Illness or Operation

\_\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_