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NAME _____

DATE _____

GYNECOLOGY HEALTH HISTORY

HOW OLD ARE YOU? . . . . . _____ years

HOW MANY TIMES HAVE YOU BEEN PREGNANT? . . . . . _____

How many abortions or miscarriages? _____
How many BIRTHS? _____
How many LIVING children? _____
How old is the YOUNGEST? _____

AT WHAT AGE DID YOU START HAVING PERIODS? . . . . . Age _____

ARE YOU REGULAR WITH YOUR MENSTRUAL CYCLE? Yes / / No / /

How many days do you flow? _____ days
Do you spot between periods? Yes / / No / /
Are your periods heavier than usual? Yes / / No / /
Are they more frequent than usual? Yes / / No / /
Are they less frequent than usual? Yes / / No / /

Do you have pain with your periods? None / / Some / / A lot / /

Date of onset of your last period? _____

Date of onset of the period before that? _____

WHEN DID YOU HAVE YOUR LAST PAP (Cancer) SMEAR? . . . . . _____

Was it normal? Yes / / No / /

DO YOU USE ANYTHING FOR BIRTH CONTROL NOW? Yes / / No / /

What do you use now? _____

What have you used in the past? _____

ARE YOU MARRIED / /, SINGLE / /, SEPARATED / /, DIVORCED / /, WIDOWED / /

REGARDING URINATION (Passing your urine):

Do you have pain while urinating? Yes / / No / /
Do you lose urine on coughing or sneezing? Yes / / No / /
Do you urinate too frequently? Yes / / No / /

WHAT MEDICATIONS DO YOU TAKE AT THIS TIME? _____

_____

_____

DO YOU HAVE AN UNUSUAL VAGINAL DISCHARGE Yes ☐ No ☐

Does it have an odor? ☐ itch? ☐ burn? ☐

IS INTERCOURSE PAINFUL Yes ☐ No ☐

DO YOU HAVE ANY QUESTIONS RE VENEREAL DISEASE? . . . . . Yes ☐ No ☐

DO YOU HAVE ANY QUESTIONS/PROBLEMS RE SEX? . . . . . Yes ☐ No ☐

WHERE WERE YOU BORN? _____

WHERE DID YOU GROW UP? _____

HAVE YOU EVER BEEN SERIOUSLY ILL (Not involving surgery)? Yes ☐ No ☐

What condition? _____

_____

_____

Have you ever had...

Diabetes	Yes ☐	Nc ☐	Cancer	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Thyroid Problem	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Nervous Disorder	Yes ☐	No ☐	Breast Problem	Yes ☐	No ☐

HAVE YOU EVER HAD SURGERY? Yes ☐ No ☐

Type? _____

_____

_____

ARE YOU ALLERGIC TO ANYTHING? . . . . . Yes ☐ No ☐

What? _____

_____

Any other specific drug or medication? _____

_____

WHAT IS YOUR HEIGHT? _____ Ft. _____ In.

WHAT IS YOUR PRESENT WEIGHT? _____ Pounds

Normal weight? _____ Pounds

WHAT IS YOUR MAIN PURPOSE FOR COMING TODAY? _____

_____

_____

_____