Gynecological Patient History Form

Please complete this form and bring it with you to your first visit. This record of your medical history is confidential and will not be given to anyone without your request or permission. By completing this form in advance you will have more time to discuss your gynecological issues and to ask questions of your doctor.

Today's Date:_____ Appointment Date: _____ Doctor:_____

Name:_____DOB: _____Age:_____

Street Address: _____City:_____State:_____Zip Code:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed Occupation:_____

Please list your phone numbers and check those at which we can leave messages and any other instructions so we can preserve your confidentiality.

Phone Numbers ☐ Home:_____☐ Cell:_____☐ Work:_____

Special Instructions_____

May we contact you by e-mail Yes_____ No_____ Email Address:_____

MENSTRUAL HISTORY

Present Symptoms or Illness:

_____

_____

_____

Describe your periods (check all that apply) ☐ Regular ☐ Irregular ☐ None ☐ Bleeding between periods

☐ Heavy ☐ Light ☐ Need medications to have period (which medications)_____

Age at first menses?_____ How many days do you bleed each month?_____

Last menstrual period (date) _____ Previous menstrual period (date) _____

Approximate number of days between the start of one period to the start of the next?_____

How painful are your periods? ☐None ☐ Mild ☐Moderate ☐ Severe What medications do you use for the pain?_____ Does the medication markedly reduce the pain? ☐Yes ☐ No

Check any premenstrual symptoms? ☐Back pain ☐ Bloating ☐ Cramps ☐Sore breasts ☐ Moodiness ☐ Other

_____

_____

GYNECOLOGIC HISTORY

Total pregnancies_____ Premature_____ Stillborn_____ Miscarriages_____

Total living children_____ Pregnancy complications_____

Vaginal discharge or irritation_____

Most recent Pap Smear (date)_____ Have you had an abnormal pap smear? ☐Yes ☐No

Have you had a mammogram within 12 mo? ☐Yes ☐No Result: ☐ Normal ☐ Abnormal

Present method of birth control_____

Difficulty with intercourse_____

Pelvic Pain_____

MEDICAL/SURGICAL HISTORY

List medications that you are currently taking_____

_____

List any allergies to medications_____

Serious illnesses_____

Operations (date & hospital)_____

_____

Other hospitalizations_____

IMMUNIZATIONS/INFECTIONS

Have you been immunized against:

Rubella ☐Yes ☐No **HPV**(cervical cancer)? ☐Yes ☐No **Hepatitis B** ☐Yes ☐No

Check any of these infections you have had?

German measles_____ Hepatitis B_____ Hepatitis C _____ Chlamydia_____

Genital herpes_____ Gonorrhea_____ Genital warts(HPV)_____

NUTRITIONAL SUPPLEMENTS, VITAMINS AND HERBAL PREPARATIONS

Please list any nutritional substances, vitamins or herbal preparations you are currently using.

_____ _____ _____ _____

_____ _____ _____ _____

LIFE STYLE

Do you exercise? ☐Yes ☐ No If yes, describe _____

How many caffeinated beverages (coffee, tea, soda) so you drink each day? _____ ☐None

Do you smoke cigarettes? ☐Yes ☐No If yes, how many each day? _____

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks each day? _____

FAMILY HISTORY

Do you have a family history of breast, ovarian or bowel cancer? ☐Yes ☐No If yes, who and at what age?

Please list any illnesses or diseases (past or present)

Father:	Alive? ☐ Y ☐ N	Age:
Mother:	Alive? ☐ Y ☐ N	Age:
Sister:	Alive? ☐ Y ☐ N	Age:
Brother:	Alive? ☐ Y ☐ N	Age:
Other Family:		

REVIEW OF SYSTEMS

Please check any current health problems and comment.

	No	Yes	List and describe any specific problems
Nervous system *Dizziness, numbness, weakness, headache, blurred vision, visual loss*			
Ear, nose and throat *Abnormal vision, hearing, swallowing*			
Gastrointestinal *Appetite, pain, indigestion, constipation, diarrhea, abdominal pain, GERD*			
Emotional *Eating disorder, bipolar disease, depression, anxiety, OCD, ADHD, schizophrenia*			
Lungs: *Asthma, chronic cough, allergies*			
Heart: *Shortness of breath, chest pain, irregular heartbeat, high blood pressure*			
BREAST: *Pain, lump, tenderness, discharge*			
URINARY: *Loss of urine, frequent infections, blood in urine, kidney stones*			
SKIN: *Rashes, persistent sores, worrisome moles, lumps, pigmented patches on skin or in skin folds, easy bruising*			
Bones, joints and muscles *Sore joints, weakness*			
ENDOCRINE: *Excessive hair growth, hair in abnormal location, weight gain/loss, skin pigment changes, thyroid problems, lack of regular cycles, diabetes, glucose intolerance*			
GLOBAL: *Fatigue, sleep disturbance, feeling of loss of well-being, anemia, elevated cholesterol or triglycerides*			
OTHER:			

Are there other current health complaints or worries about any particular disease?			

EXPECTATIONS AND QUESTIONS

What are your expectations from your visit and what questions do you want answered?