PATIENT HEALTH HISTORY

Gynecologic and Genitourinary Problems (Please check all that apply.)
☐ Heavy periods ☐ Frequent periods ☐ Absent or infrequent periods ☐ Cramps
☐ Abnormal Pap ☐ Vaginal discharge ☐ Vaginal itching ☐ Vaginal dryness
☐ Pelvic Pain ☐ Endometriosis ☐ Ovarian cysts ☐ Fibroids ☐ Uterine polyps
☐ Premenstrual symptoms ☐ Bleeding with intercourse ☐ Pain with intercourse
☐ Sexual problems ☐ Infertility ☐ Pelvic organ prolapse ☐ Frequent bladder infections
☐ Urine leakage ☐ Urinary frequency ☐ Urinary urgency ☐ Osteoporosis
☐ Abnormal Mammogram ☐ Breast lump ☐ Breast pain ☐ Nipple discharge
☐ Hot flashes ☐ Mood changes ☐ Postmenopausal bleeding
☐ Other:

__________________________________________________________

Sexually Transmitted Infection History (Please check all that apply)
☐ Gonorrhea ☐ Chlamydia ☐ Pelvic Inflammatory Disease (PID) ☐ HIV ☐ Herpes
☐ Trichomonas ☐ Syphilis ☐ Genital warts ☐ HPV ☐ Hepatitis B ☐ Hepatitis C

PAST SURGERIES and HOSPITALIZATIONS:

__________________________________________________________

MEDICATIONS: (Please list current medication, dose, and frequency.)

__________________________________________________________

VACCINES:

__________________________________________________________

ALLERGIES: (Please list any medications, latex, or other allergies followed by reaction.)

__________________________________________________________

PAST MEDICAL HISTORY: (Please check all that apply.)
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Cancer
☐ Seizures ☐ Thyroid Disease ☐ High Cholesterol ☐ Asthma ☐ Anemia
☐ Blood Clots ☐ Kidney Disease ☐ Liver Disease ☐ Gastrointestinal Disorders
☐ Eating Disorder ☐ Depression ☐ Anxiety ☐ Psychiatric Disorder ☐ Headaches
☐ Other:

__________________________________________________________

SOCIAL HISTORY:
Highest education level: ____________________________
Are you a student? □ Yes □ No If Yes, what grade level? ___________________
What is your stress level? □ Low □ Medium □ High
Do you exercise regularly? □ Yes □ No If Yes, what type of exercise? ___________________ How often? _____________
What type of diet do you follow?
□ Regular □ Vegetarian □ Vegan □ Gluten-free □ Other: ___________________________
Tobacco use? □ Yes □ No If Yes, how many cigarettes per day? ______ How long? _____________
Alcohol use? □ Yes □ No If Yes, how many drinks per week? ______
Drug use? □ Yes □ No If Yes, what type? ___________________ How often? _____________
Caffeine? □ None □ Occasional □ Moderate □ Heavy
Are you sexually active? □ Yes □ No If yes, how many partners? _______________
Do you have unprotected sex? □ Never □ Sometimes □ Always
Have you ever been physically or sexually abused? □ Yes □ No
Are you being abused now? □ Yes □ No

FAMILY HISTORY:
Check here if adopted or unknown family history.
Disease Family Member(s) Age at Diagnosis *Please specify maternal (mother’s side) or paternal (father’s side)
□ Breast Cancer __________________________ _
□ Gynecologic Cancer __________________________ _
(Uterine, Ovarian, Cervical, etc.)
□ Other Cancers (list type) __________________________ _
(Colon, Melanoma, Lung, etc.)
□ Heart Disease __________________________ _
□ Hypertension __________________________ _
□ High Cholesterol or Triglycerides __________________________ _
□ Diabetes __________________________ _
□ Osteoporosis, Bone Fractures __________________________ _
□ Blood Clots __________________________ _
□ Alzheimer’s Disease __________________________ _

GYNECOLOGIC HISTORY:
Age of first period _____ years First day of last period ___________
Interval between periods _____ days Length of each period _____ days
Amount of pads/ tampons used per day ______
Age of first intercourse ___________________ Sex with Men □ Women □ Both
Current method of birth control: ___________________________
Desired method of birth control: ____________________________________________________

Date of last Pap smear: ______________________ □ Normal □ Abnormal
Date of last mammogram: ____________________ □ Normal □ Abnormal
Date of last colonoscopy: _____________________
Date of last bone density scan: ________________

Gynecologic Surgical History *(Please list year and procedure)*
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

FAMILY PHYSICIAN/ PCP INFORMATION
Practice Name: _________________________________________________________________
Physician Name: ________________________________________________________________
Office Address: __________________________________________________________________
Office Phone: _____________________

PHARMACY INFORMATION
Primary Pharmacy: ________________ Secondary Pharmacy: ________________
Address: __________________________ Address: ________________________________
____________________________________
Phone: ___________________________ Phone: _______________________________

OBSTETRIC HISTORY :
Have you ever been pregnant? □ Yes □ No *(If No, please skip to next section.)*
How many times have you been pregnant? _____
How many living children do you have? _____

Vaginal Deliveries (Dates):
____________________________________________________________________________
Cesarean Deliveries (Dates): ______________________________________________________
Preterm Deliveries (Dates):
____________________________________________________________________________
Miscarriages (Dates):
____________________________________________________________________________
Abortions (Dates):
____________________________________________________________________________
Ectopic Pregnancies (Dates):
____________________________________________________________________________

Obstetrical Complications *(Please check all that apply.)*
□ Diabetes in pregnancy □ Pre-eclampsia □ Eclampsia □ Stillbirth □ Fetal anomaly
□ Poor fetal growth (IUGR) □ Excessive fetal growth (Macrosomia)
□ Placental abruption □ Placenta previa (placenta covers the cervical os)
Postpartum hemorrhage  ☐ Preterm labor  ☐ Premature delivery
☐ Twin pregnancy  ☐ Triplet or higher pregnancy
☐ Low amniotic fluid (Oligohydramnios)  ☐ High amniotic fluid (Polyhydramnios)
☐ Cervical insufficiency or Loss of second-trimester pregnancy  ☐ Recurrent miscarriage
☐ Other:
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________________________________________
________________________________________

QUESTIONS:  Do you have any particular concerns, needs, questions or comments?
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