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:

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