GYNECOLOGY HISTORY RECORD AND PATIENT QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Is your visit today for: ☐ Your annual ☐ Pregnancy ☐ A problem

If being seen for a problem, please list reason: _____

PAST MEDICAL HISTORY

MEDICATIONS

Are you taking medication(s) regularly? YES NO

If yes, please list the name(s), dosages, and prescriber:

_____

_____

_____

_____

ALLERGIES

Are you have an allergy to latex? YES NO

Are you allergic to any medications?

If yes, please list the name(s) below and the reaction:

_____

_____

_____

FAMILY HISTORY:

Have any of your ***blood relatives*** had any of the following conditions? Circle "Yes" or "No" and list relation and their age.

Breast Cancer:	YES	NO	_____
Ovarian Cancer:	YES	NO	_____
Colon Cancer:	YES	NO	_____
Uterine Cancer:	YES	NO	_____
Diabetes	YES	NO	_____

SOCIAL HISTORY:

Do you use drugs? YES NO

Do you smoke? YES NO

If yes, how many per day? _____

Do you Drink Alcohol? YES NO

If yes, how many drinks per day/week? _____

Do you exercise regularly? YES NO

HOSPITAL/SURGICAL HISTORY:

_____

_____

_____

PRIMARY CARE PHYSICIAN

_____

PREGNANCY HISTORY: (Enter total number in each)

Pregnancies: _____ Abortions: _____

Live Births: _____ Stillborn: _____

Miscarriages: _____ Living: _____

Age at time of first child: _____

PAP SMEAR HISTORY:

Last PAP smear date: _____

Results: ☐ Normal ☐ Abnormal

Abnormal PAPS in the Past? YES NO

If yes, list date(s), tests/treatments:

_____

MAMMOGRAMS

Date of last Mammogram: _____

Location: _____

Because abuse and violence are so common in women's lives, we have begun to ask routinely, are you in a relationship in which you have been physically hurt or threated by your partner? YES NO

Patient Name: _____ Date of Birth: _____

Have you had any of the following conditions?

Cancer YES NO
If yes what kind? Diagnosis Date: _____
Diabetes YES NO
Gallbladder/Gastrointestinal/Liver YES NO
Heart Problems/High Blood Pressure YES NO
Thrombophlebits/Blood Clots YES NO
High Cholesterol YES NO
Last Cholesterol Check Date _____ Result if Known _____
Sickle Cell Anemia/ Blood Disorders YES NO
Blood Transfusion YES NO
Thyroid Disease YES NO
Migraine/Vascular Headaches YES NO
Rheumatic Fever as a child YES NO
Infection of Fallopian Tubes YES NO
Recurrent Urinary Tract Infections YES NO
Kidney Problems YES NO
Asthma/TB YES NO
Hepatits YES NO
Sexually Tramismitted Disease YES NO
If yes, circle which ones: Herpes Genital Warts Gonoorrhea Chlamydia Syphillis
Psychiatric Diagnosis YES NO
If so Which Diagnosis: _____
Serious Injuries YES NO
Loss of urine while coughing YES NO
Urinary Urgency YES NO
Constipation YES NO
Mitral Valve Proplapse YES NO
Any heart condition requiring anitbiotics before surgery or dental procedure YES NO

MENSTRUAL HISTORY:

At what age did you periods begin? _____
Interval between periods (first day to first day): _____
How long do your periods last? _____
Amount of flow: ☐ Light ☐ Moderate ☐ Heavy
Cramping: ☐ Light ☐ Moderate ☐ Heavy
LMP (1st day of last period): _____
At what age did you go through menopause?

CONTRACEPTIVES

Contraceptive method used now: _____

What is your preferred pharmacy? _____

Most testing is sent to an outside lab. You will receive a separate bill from that lab for these services

Reviewed By: _____