Gynecology Health History

ID No.: _____

Today's Date: ____ / ____ / ____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: _____

Address: _____

_____

Home Telephone No: ( ) _____

Work Telephone No: ( ) _____

Reason for Seeing Doctor _____

Date of Birth: ____ / ____ / ____ Age: _____ Religion: _____

Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race: _____

Education: _____ years Occupation: _____

Employer: _____

Type of Insurance: _____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

1. CURRENT MEDICATIONS ❑ None

_____

_____

2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____

_____

_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
3. High Cholesterol	❑	❑
4. Heart Disease	❑	❑
5. Rheumatic Fever	❑	
6. High Blood Pressure	❑	❑
7. Asthma	❑	
8. Tuberculosis	❑	
9. Diabetes	❑	❑
10. Thyroid Problems	❑	❑
11. Liver Disease	❑	
12. Stomach, Bowel or Gall Bladder Problems	❑	
13. Kidney or Bladder Problems	❑	
14. AIDS (HIV)	❑	❑
15. Hepatitis (type ___)	❑	❑
16. Anemia or Blood Disorder	❑	❑
17. Blood Transfusion	❑	
18. Allergies	❑	
19. Breast Problems	❑	❑
20. Cancer	❑	❑
21. Infertility	❑	
22. Female or Sexual Problems	❑	
23. Chlamydia	❑	
24. Gonorrhea	❑	
25. Herpes (HSV)	❑	
26. Syphilis	❑	
27. Birth Defects or Inherited Diseases	❑	❑
28. Sexual Abuse or Domestic Violence	❑	❑
29. Other Medical Problems	❑	❑
30. **No Known Medical Problems**	❑	❑

31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	Complications No
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ❑
Type _____
Amt/day _____

33. Tobacco ❑
Type _____
Amt/day _____

34. Caffeine ❑
Type _____
Amt/day _____

35. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	Complications No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____ / ____ / ____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

39. CONTRACEPTIVE HISTORY

Type		Dates Used
Oral Contraceptive	❑	_____
Type(s) _____	❑	_____
_____	❑	_____
IUD	❑	_____
Diaphragm	❑	_____
Norplant	❑	_____
Sponge	❑	_____
Spermicide	❑	_____
Condoms	❑	_____
Other _____	❑	_____

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
40. Did your mother take DES or any other hormones when pregnant with you?	❑	❑
41. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap test? ___ / ___ / ___		
Have you ever had abnormal Pap test results?	❑	❑
42. Are you sexually active?	❑	❑
43. Do you have one partner or	❑	one
many partners	❑	many
44. Is intercourse painful for you?	❑	❑
45. Do you do a monthly self breast exam?	❑	❑
46. Have you ever had a mammogram?	❑	❑
If Yes: Date of your last mammogram? ___ / ___ / ___		
47. Do you exercise on a regular basis?	❑	❑

If Yes: Type of exercise _____

Hours per week exercise _____

Check and detail positive findings below. Use reference numbers.

Signature: _____