

PATIENT HISTORY

NAME: _____ Reviewed _____ Pt initials _____ MD _____

Date: _____ / _____ / _____

Referred by: _____

Number of pregnancies: _____ Number of children: _____ Patients Date of birth _____ / _____ / _____

GYN HISTORY	<i>YES</i>	<i>NO</i>	
Are your periods regular, once a month?	<input type="checkbox"/>	<input type="checkbox"/>	Are you in a single partner relationship? <input type="checkbox"/> yes <input type="checkbox"/> no Current contraception? <input type="checkbox"/> none <input type="checkbox"/> condoms <input type="checkbox"/> pills <input type="checkbox"/> depo provera shot <input type="checkbox"/> patch <input type="checkbox"/> IUD <input type="checkbox"/> vaginal ring <input type="checkbox"/> diaphragm <input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy <input type="checkbox"/> rhythm method
Do you have cramps with your periods?	<input type="checkbox"/>	<input type="checkbox"/>	
Any bleeding between your periods?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
If so, is partner <input type="checkbox"/> male <input type="checkbox"/> female			Any history of: <input type="checkbox"/> ovarian cyst <input type="checkbox"/> fibroids <input type="checkbox"/> breast lump/breast disease
Duration _____ months or _____ years			

	<i>YES</i>	<i>NO</i>
<i>Please check if you have ever been treated for any of the following infections:</i>		
Vaginal bacterial infection/BV/Vaginosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Warts <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you <i>ever</i> had an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
When? _____ (w/in 3 years=HR)		
Has it been more than 7 years since your last pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had more than 5 sexual partners in you lifetime?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with HIV?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take the drug DES while pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL PROBLEMS	<i>YES</i>	<i>NO</i>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	MEDICAL PROBLEMS <i>YES</i> <i>NO</i> Blood clots in veins/artries <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Blood transfusions <input type="checkbox"/> <input type="checkbox"/> Seizures/convulsions/epilepsy <input type="checkbox"/> <input type="checkbox"/> Bowel problems <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Hepatitis/jaundice <input type="checkbox"/> <input type="checkbox"/> Other _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma/chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	
Heart trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/> type _____	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	

OPERATIONS	<i>YES</i>	<i>NO</i>	<i>DATE</i>
C-section	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY HISTORY	<i>YES</i>	<i>NO</i>	<i>WHO?</i>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICATIONS: <input type="checkbox"/> none	ALLERGIES: <input type="checkbox"/> none
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SOCIAL HISTORY	<i>YES</i>	<i>NO</i>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? <input type="checkbox"/> <input type="checkbox"/> Do you eat a diet high in fat/sugar? <input type="checkbox"/> <input type="checkbox"/> Do you wear a seat belt? <input type="checkbox"/> <input type="checkbox"/>
Do you drink alcohol at all?	<input type="checkbox"/>	<input type="checkbox"/>	
Avg. # drinks/day _____			
Do you use any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel safe in your home/relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No

OB HISTORY (Please indicate all pregnancies including miscarriages, ectopics, etc.)					
DATE	TYPE OF DELIVERY OR MISCARRIAGE	LOCATION/MD	WEIGHT	NAME	COMPLICATIONS