

PATIENT HISTORY

NAME: _____ Reviewed _____ Pt initials _____ MD _____

Date: _____ / _____ / _____

Referred by: _____

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

GYN HISTORY	YES	NO	
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 Any history of: <input type="checkbox"/> ovarian cyst <input type="checkbox"/> fibroids <input type="checkbox"/> breast lump/breast disease
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			
Duration _____ months or _____ years			

<i>Please check if you have ever been treated for any of the following infections:</i>	YES	NO
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"/>
Gonorrhoea <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	YES	NO	MEDICAL PROBLEMS	YES	NO
High blood pressure <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in veins/artries <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/chronic lung disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infection/stones <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble/murmur <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> type _____	Seizures/convulsions/epilepsy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other		

OPERATIONS	YES	NO	DATE	OPERATIONS	YES	NO	DATE
C-section <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Gall bladder removed <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Breast biopsy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian surgery <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other surgery/hospitalization:			
Tubal ligation <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____			
Appendectomy <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		_____			

FAMILY HISTORY	YES	NO	WHO?	FAMILY HISTORY	YES	NO	WHO?
Breast cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart attack/stroke before age 50 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Blood clot requiring blood thinners <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other: _____			

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