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: ____________