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GYNECOLOGIC MEDICAL HISTORY

DATE _____

PLEASE ANSWER EVERY QUESTION (Use reverse side if needed) FULL NAME _____

PREFERRED NAME/NICKNAME: _____ OCCUPATION: _____ AGE: _____

MEDICAL HISTORY CIRCLE IF YOU HAVE A PERSONAL HISTORY OF:

Cancer, Diabetes, High Blood Pressure, Seizures, DES Exposure, Blood Transfusion, Heart Murmur, Heart Disease, Migraine, Asthma, IBS
 Abnormal Pap Smear, Thrombophlebitis, Deep Vein Thrombosis (DVT), frequent Urinary Tract Infection, Depression/Anxiety, Gastric Reflux,
 Kidney Stones, Thyroid Disease, Genital Herpes, Chlamydia, Gonorrhea, Venereal Warts, Hepatitis, HIV/AIDs, other STD

ANY OTHER MEDICAL CONDITION? YES NO List if Yes: _____ NONE OF THE ABOVE

List all ALLERGIES and reaction (nausea, hives, etc.) _____ NO ALLERGIES

List all current MEDICATIONS and doses include vitamins, calcium, herbs and nonprescription meds. _____ NO MEDS

List all SURGERIES and dates _____ NO SURGERIES

FAMILY HISTORY Parents and Siblings Alive and Well? Yes No If deceased, list cause

Circle if any family history of: Diabetes, Heart Attacks Thrombophlebitis, Cancer, Death from anesthesia, Bleeding disorder, Stroke,
 High Blood Pressure, Osteoporosis, Birth Defect, Mental Retardation YES NO Who:

SOCIAL HISTORY Marital Status _____ Years/Months with current partner (if applicable)

Packs/day CIGARETTES: 1/2 1 2+ never quit/when? ALCOHOL never rarely weekly daily quit/when? CAFFEINE (cups/day) 0 1 2 3+

REVIEW OF SYSTEMS: Circle and CURRENT significant or unexplained symptoms

Cough, Sore Throat, Chest pain, shortness of breath, Heart palpitations, Visual changes, Unexplained weight change, Fevers, Nausea, Vomiting,
 Change in bowels, Abnormal vaginal bleeding, Abdominal pain, Urinary pain, Frequent urination, significant urinary Leakage,
 Severe or frequent Headaches, Muscle Weakness, Depression/Anxiety, Night Sweats, Rashes, Joint swelling _____ NONE OF THE ABOVE

List any other significant symptoms:

| | | | |
|--------------------------|---------------------------------|-----------------------------|-----------------------------------|
| MENSTRUAL HISTORY | Last menstrual period (1st day) | Normal? Yes No | Previous period |
| Age of first period | How frequently do they come? | How many days do they last? | FLOW: Heavy Medium Light |
| Bad Cramps? Yes No | Bleeding in between? Yes No | Abnormal discharge Yes No | Date of last pap smear |
| Method of contraception: | Date of last mammogram | Normal? Yes No | History of Breast Problems Yes No |

| | | | |
|--|--|--|--|
| Date: | | | |
| Delivery Route – vaginal, c-sec Forceps, vacuum, D&C | | | |
| Complications (bleeding, diabetes, hypertension, infection) | | | |
| Sex (F or M), name | | | |
| Weight | | | |

Office Use Only: Ht: _____ Wt: _____ BP: _____ Temp: _____ Pulse: _____ Urine: _____ Alb: _____ Glu: _____ Bld: _____