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GYN PATIENT HISTORY:

Date: _____

Name: _____ Date of Birth: _____ Age: ____

Marital Status: S___ M___ D___ W___ Sep ___ Occupation: _____

Reason for Today's Visit: _____

_____

Obstetrical / Gyn History:

Total # of Pregnancies _____ # of Full Term _____ # of Premature _____

# of Living Children _____ Age of Oldest Living Child _____ Age of Youngest Living Child _____

# of Multiple Pregnancies _____ # of Spontaneous Abortions _____

# of Voluntary Induced Abortions _____ # of Tubal Pregnancies _____

Menstrual History

First day of your last period: _____ How many days does your period last? _____

How many days are there from the end of a period to the beginning of the next period? _____

Age of your first period: _____ Are you currently menopausal? _____ If so, at what age

did menopause begin? _____

Are you currently pregnant? _____ If you are pregnant, were you taking any hormonal

contraceptives prior to or during the pregnancy? _____

Review of Systems

Please check if any of the following apply to you currently or in the past:

1. General	Current	Past	Describe
Change in weight			
Change in appetite			
Fatigue			
Life style changes			
Fever			
2. HEENT			
Headaches			
Vision changes			
Double vision			
Spots before eyes			
Hearing changes			
Ringing in ears			
Sinus problems			

2. HEENT (cont.)	Current	Past	Describe
Sore throat			
Mouth sores			
Dizziness			
Neck Stiffness			
3. Breast			
Breast pain / tenderness			
Breast lumps			
Nipple discharge			
Bleeding from nipples			
Swelling or redness			
4. Respiratory			
Cough			
Difficulty breathing			
Wheezing			
Sputum / mucous production			
Pain with respiration			
5. Cardiovascular			
Chest pain			
Shoulder, arm, leg or neck pain			
Shortness of breath			
Irregular heart beat			
6. Gastrointestinal			
Abdominal pain			
Nausea / vomiting			
Constipation			
Diarrhea			
Heartburn			
Blood in stools			
Change in bowel habits			
7. Endocrine			
Weight Change			
Excessive thirst / urination			
Heat / cold intolerance			
Lump in neck			
Excessive sweating			
8. Gynecological			
Missed periods			
Irregular menstrual cycles			
Excessive bleeding during periods			
Bleeding between periods			
Pain / cramping during periods			
Pain with intercourse			
Vaginal discharge / odor			
Vulvar / vaginal itching or burning			
Pelvic pain			

9. Urological	Current	Past	Describe
Pain with urination			
Blood in urine			
Frequency of urination			
Urinary urgency			
Leakage when coughing / sneezing			
Incomplete bladder emptying			
10. Musculoskeletal			
Muscle weakness			
Back pain			
Joint pain, swelling, stiffness			
Loss of range of motion			
11. Neurological / Psychological			
Headaches			
Anxiety			
Depression			
Mood swings			
Numbness or tingling			
Seizures			
12. Integument (Skin)			
Rash / Itching			
Change in moles or lesions			
Ulcers			
Hair loss			
13. Hematologic / Lymphatic			
Enlarged lymph glands			
Abnormal bruising			
Abnormal tendency to bleed			

Past Medical History

Date of last pap smear: _____ Results: Normal _____ Abnormal _____

If you have had abnormal pap smears in the past then list all dates and, if known, the abnormalities found: _____

_____

Date of last mammogram: _____ Results: Normal _____ Abnormal _____

If you have had abnormal mammograms in the past then list all dates: _____

_____

List all previous surgeries:

Date	Operation	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all previous surgeries (cont.):

Date	Operation	Reason

Past Medical History, Continued

The following refers to your own past medical history (not your family):
Please check if any of the following apply to you.

	Yes	No	Description and Age of Onset
1. Malignancies (Cancer)			
2. Head, Ears, Eyes, Nose, Throat			
3. Respiratory (Lungs)			
4. CVD (Heart Problems)			
5. Gastrointestinal			
6. Gynecologic (Sexually Transmitted Diseases)			
7. Urinary			
8. Musculoskeletal Disorders			
9. Integument (Skin)			
10. Neurological / Psychological			
11. Endocrine / Hormonal Problems			
12. Hematological (Blood)			
13. Infectious Diseases			
14. Genetic Birth Defects			
15. Immunizations			

Family History

The following applies to only members of your family (when listing grandparents, aunts or uncles, please identify whether they are maternal (m) or paternal (p)).

Type of Illness	Relationship	Comments
Blood Disorders		
Breast Cancer		
Cervical Cancer		
Cardiovascular Disease		
Diabetes		
GI Cancer		
Hypertension / High Blood Press.		
Lung Cancer		

Type of Illness (cont.)	Relationship	Comments
Lymphatic Cancer		
Malignancies (Other than listed)		
Ovarian Cancer		
Renal Disease		
Stroke		
Uterine Cancer		
Other Illnesses		

Social Habits

Current form of birth control: _____

Do you use tobacco? _____ _Packs/Day? _____ How long have you used tobacco? _____

Do you drink alcohol? _____ How many drinks and how often? _____

How long have you used alcohol? _____

Do you use laxatives? _____How often? _____ How long have you used laxatives? _____

Do you use street drugs? _____ What type and how often? _____

How long have you used street drugs? _____

Allergies

List all medications that you are allergic to: _____

_____

_____

Current Medications

List all medications that you are currently taking and the reason why (include over the counter medications) _____

_____

_____

_____