GYN Patient History (Please include as much detail as possible)

Today's Date: _____

Name: _____ DOB: _____ Age: ___ Occupation: _____

Referred by: _____ Primary Provider: _____

Reason for visit _____

_____

OBSTETRICAL-HISTORY:

Are you planning pregnancy? Yes / No If yes, when: _____

# of pregnancies _____ (Please include: miscarriages, abortions, ectopic pregnancies)

Date Delivery type Complications Length of Pregn(Weeks/Mo) Sex/weight

1. _____
2. _____
3. _____
4. _____

GYNECOLOGIC HISTORY:

PERIODS: Age at first period: ___

Yes No

__ __ Are you having periods?

If ***YES***: Date of last period _____

If ***NO***:Hysterectomy (date) _____ Reason _____ Ovaries Removed: Yes / No

Menopause, at age _____ Natural / Surgical

Other: _____

__ __ Do you have concerns about your periods? _____

__ __ Do you have a sex partner?

If Yes, are your sexual partners: (*please circle*) Men, Women, Both

__ __ Have you ever had a sexually transmitted infection? What? _____

(Condylomata. HPV, Herpes, Gonorrhea, Chlamydia, Syphilis, PID. HIV, Hepatitis)

__ __ Have you ever been in a relationship in which: threats, shoving, hitting, slapping, kicking or other hurting was used by someone? Would you like to discuss this today? Yes / No

PAP SMEARS: Date of last pap smear: _____ Where? _____

Have you ever had:

__ __ An abnormal pap smear? When? _____

__ __ Colposcopy? (microscopic look at cervix)

__ __ Freezing / burning of cervix, or cone biopsy? _____

__ __ Did your mother take DES while she was pregnant with you?

BREASTS: Date of last mammogram _____ Where? _____ Results: _____

__ __ Have you ever had problems with your breasts? What? _____

__ __ Do you perform breast self-exam monthly? _____ How Often?

TB test: [ ] Yes [ ] No Result / When? _____

Tetanus shot, when?: _____

PAST MEDICAL HISTORY: (List any medical problems, diagnoses, or hospitalizations with dates)

_____

_____

_____

PAST SURGERIES: (include dates and all surgeries, even "minor" surgeries)

_____

_____

_____

FAMILY-HISTORY:

If family history not known (*please circle*): **Maternal / Paternal / Both**

Yes	No		Who	Yes	No		Who
__	___	Breast cancer	_____	__	___	Melanoma/Skin Cancer	_____
__	___	Ovarian cancer	_____	__	___	Insulin dependent diabetes	_____
__	___	Uterine cancer	_____	__	___	Heart Attack or Stroke	_____
__	___	Colon cancer	_____	__	___	Blood clots	_____
__	___	Osteoporosis	_____	__	___	Alcoholism	_____
__	___	Thyroid disorder	_____	__	___	Depression / Anxiety	_____

REVIEW OF SYSTEMS: Please check (X) any of the following that apply to you.

	CURRENT	PAST	COMMENTS
1. Skin			
Change in moles/freckles	_____	_____	_____
2. Eyes: Vision changes	_____	_____	_____
3. Ears, Nose, Throat / Mouth:	_____	_____	_____
4. Cardiovascular			
Chest Pain / Palpitations	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Heart murmur or problems requiring antibiotics	_____	_____	_____
5. Respiratory			
Asthma / wheezing shortness of breath, cough	_____	_____	_____
6. Gastrointestinal			
Change in bowel habits	_____	_____	_____
Hepatitis / Liver disease	_____	_____	_____
7. Genitourinary			
Urgency/frequency	_____	_____	_____
Leakage of urine	_____	_____	_____
8. Breast			
Persistent pain in breast	_____	_____	_____
Nipple discharge	_____	_____	_____
Breast lump	_____	_____	_____
9. Neurologic			
Migraine headaches, numbness dizziness, sinus trouble	_____	_____	_____
10. Psychiatric			
Depression	_____	_____	_____
Anxiety	_____	_____	_____
11. Endocrine			
Heat or cold intolerance	_____	_____	_____
Abnormal thirst	_____	_____	_____
Hotflashes	_____	_____	_____
Thyroid problems	_____	_____	_____
Diabetes (even in pregnancy)	_____	_____	_____
Unexplained weight Loss / Gain	_____	_____	_____
12. Hematological / Lymphatic			
Cuts that don't stop bleeding	_____	_____	_____
Blood clots in veins	_____	_____	_____
13. Musculoskeletal			
Bone & joint pain	_____	_____	_____

Signature of Patient: _____

Date reviewed: _____ Provider Signature: _____

Date reviewed: _____ Provider Signature: _____

Date reviewed: _____ Provider Signature: _____

Date reviewed: _____ Provider Signature: _____