



Date: ____ / ____ , 200__

Patient Name – Please Print _____

Page 1 of 2

GYNECOLOGICAL HISTORY

Menstrual Cycle

Do you menstruate? Yes No Age at which your periods began? _____ Ended? _____
Are they regular irregular? Is your flow: heavy moderate light?
Periods occur every # _____ days and last for # _____ days. If you have cramps, are they severe moderate light?
What medications, if any, do you take for cramps? _____
Are you menopausal? No Yes: if so, ever take hormone replacement? No Yes, for _____ year (s) _____ months
Do you take vitamins or calcium for menstrual / menopausal symptoms? No Yes: _____
Do you have any premenstrual symptoms that are significantly disturbing to you? Please describe: _____

Have you ever had long periods of time (>6 mos) when you did not menstruate? Please describe: _____

Breasts Have you ever had: Excessive tenderness Nipple Discharge Mastitis or Breast Abscess?

Have you had any cosmetic breast surgery? Describe/Give Dates: _____

Have you ever had a breast biopsy? No Yes: give dates and results: _____

Have you had surgery for breast cancer? No Yes: give dates/results: _____

Have you had radiation therapy or chemotherapy for breast cancer? No Yes: _____

Your History: Please check all that apply and give dates on line below.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Genital warts (HPV) | <input type="checkbox"/> Herpes > <input type="checkbox"/> genital <input type="checkbox"/> oral | <input type="checkbox"/> Bartholin Abscess/Cyst | <input type="checkbox"/> Abnormal Uterine Bleeding |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Vaginitis, recurrent/problem | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> PID-pelvic inflammatory disease | <input type="checkbox"/> Ovarian Cyst | <input type="checkbox"/> DES Exposure |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> IUD-related infection | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Vulvar skin disorders |

Dates: _____

Have you had any *Gynecologic Surgery*? Please describe/give dates: _____

Drug / Latex Allergies: Please tell us type and reaction. Do NOT include seasonal allergies: _____

Pap Smears

Have you ever had an abnormal PAP smear? No Yes: When? _____

Do you know what the PAP abnormality was? No Yes: _____

Did you have a **colposcopy** done? No Yes – if so: With biopsy No biopsy

Were you diagnosed with dysplasia? No Yes: mild moderate severe

If you were treated, please check type of treatment and give dates:

<input type="checkbox"/> Cryosurgery: _____	<input type="checkbox"/> LOOP/LEEP: _____	<input type="checkbox"/> Laser Procedure: _____
<input type="checkbox"/> Cautery: _____	<input type="checkbox"/> Cone Biopsy: _____	<input type="checkbox"/> NO TREATMENT

Sexual History

Age sexual relations began? _____ years Ever been sexually active with men? women? both?

Are you currently in a sexual relationship with a man? woman? multiple partners?

Do you have any known or suspected history of sex abuse or rape? (Please describe only if you wish) _____

Are there any sexual issues that you would like to discuss? _____

Birth Control Have you ever used the following and for how long?

IUD: _____ // Birth Control Pills: _____ // Norplant ®: _____

Please check any of the following that you have used:

- | | | | | |
|--|-------------------------------------|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Condoms | <input type="checkbox"/> Spermicides | <input type="checkbox"/> Rhythm | <input type="checkbox"/> Cervical Cap |
| <input type="checkbox"/> Sterilization | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Fertility Awareness | | |

(Continued on page 2)



Date: ____ / ____ , 200__

Patient Name – Please Print _____

Page 2 of 2

PREGNANCY HISTORY – Biologic or Adopted Children

Please list all pregnancies and any complications.

YEAR	LIVE BIRTH	BOY or GIRL	VAGINAL BIRTH	C-SECTION	ABORTION	MISCARRIAGE	ECTOPIC	ADOPTED	COMPLICATIONS

Additional Information: _____

PERSONAL/SOCIAL HISTORY

Do you have any history of drug or alcohol abuse? _____
 Do you have or have you ever had an eating disorder? _____
 Are you comfortable with your present body weight and your present diet? _____
 Have you smoked cigarettes? ___ No ___ Yes-If so, are you ___ still smoking? ___ Quit in ___ (year) Smoked for ___ yrs
 Do you exercise regularly? ___ No ___ Yes ___ Somewhat : Describe: _____
 Have you ever been in therapy or counseling? ___ No ___ Yes: _____

PERSONAL MEDICAL HISTORY Please check all that apply and describe in space below. *Do Not* include family history.

___ High Blood Pressure ___ Heart Disease ___ Lung Disease ___ Liver Disease ___ Kidney Disease ___ HIV Disease
 ___ Gastrointestinal (ulcer, colitis, gallbladder) ___ Migraine Headaches ___ Bleeding Abnormalities ___ DVT/History of Clots
 ___ Cancer/Leukemia/Lymphoma ___ Endocrine Disorders (Diabetes, thyroid, etc) ___ Neurologic/Psychiatric Disorders
 ___ Depression/Anxiety ___ Any Other Medical Conditions: _____

Additional Information: _____

OPERATIONS/TRANSFUSIONS Describe and give dates: _____

HOSPITAL ADMISSIONS (Non-Surgical-Non Childbirth)

FAMILY HISTORY Who has the following? (Biologic and Adoptive) Use: (M)-Mother (F)-Father (S)-Sibling (C)-Children (MG)-Maternal Grandmother (MGF)-Maternal Grandfather (PG)-Paternal Grandmother (PGF)-Paternal Grandfather

___ Breast Cancer ___ Ovarian Cancer ___ Colon Cancer ___ Other Cancer ___ Diabetes
 ___ Heart Disease/Stroke ___ High Blood Pressure ___ Neurologic/Psychiatric ___ Osteoporosis

Alive (A) or Deceased (D)? ___ Mother ___ Father ___ Children ___ Siblings

Describe any other health problems in family not addressed above: _____

(Patient Signature) _____ MD/NP/CMN Signature: _____

