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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, Intellectual Disability YES NO Who:

SOCIAL HISTORY Marital Status Years/Months with current partner (if applicable)
Packs/day CIGARETTES: ½ 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
Age of first period | Last menstrual period (1st day) | Normal? Yes No | Previous period
Bad Cramps? Yes No | How frequently do they come? | How many days do they last? | FLOW: Heavy Medium Light
Method of contraception: | Bleeding in between? Yes No | Abnormal discharge Yes No | Date of last pap smear
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: