



Gynecology Medical History

Name: _____ Date: _____

ID #: _____ Birth date: _____ Age: _____

Family Background: Has anyone in your Family/Blood Relatives had any of the following?

Yes	No	Medical Problem	Relation & Dates
		Breast Cancer	
		Cervical / Ovarian Cancer	
		Other breast, gyn, infertility problems	
		Diabetes	
		High Blood Pressure	
		Stroke / Heart Attack	
		Alcoholism / Drug abuse	
		Other cancer or serious illness	
		Thyroid disease	
		Did you mother take hormones (DES) during pregnancy with you?	

Personal History: Check off any conditions you currently have or have had in the past.

<input type="checkbox"/>	Smoke(d) cigarettes	<input type="checkbox"/>	Heart trouble / Murmur	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	Use(d) alcohol	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Hepatitis / Liver problems
<input type="checkbox"/>	Use(d) recreational drugs	<input type="checkbox"/>	Chest pain / Asthma	<input type="checkbox"/>	Gallbladder disease
<input type="checkbox"/>	Use(d) IV drugs	<input type="checkbox"/>	Blood clot / Vein problems	<input type="checkbox"/>	Urinary / Kidney problems
<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Suspected / diagnosed cancer
<input type="checkbox"/>	Severe anemia	<input type="checkbox"/>	Seizures / Epilepsy	<input type="checkbox"/>	
<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	

Explanation for above: _____

Yes	No	
		Have you been treated by a physician in the last month?
		Are you currently taking prescription/non-prescription medications, diet pills, vitamins, or using birth contraceptives?
		Do you follow a special or restricted diet?
		Do you have or have you had anorexia or bulimia?
		Do you exercise regularly? What type and how often per week?

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Menstrual History

Age of first menstruation: _____ Average # of flow days: _____ Cycle length: _____

Date and result of last pap smear: _____

Yes	No	
		Are your periods regular?
		Do you have severe cramps? Medications taken:
		Have you had to seek medical attention for excessive bleeding: If yes, explain:
		Do you have any problems with PMS? List symptoms:

Gynecological / Sexual History

Number of male partners in last year _____ In last 10 years (1-3) _____ (4-7) _____ 8 or more _____

Number of female partners in last year _____ In last 10 years (1-3) _____ (4-7) _____ 8 or more _____

Was any partner an IV drug user or bisexual? Yes No Unknown

Have you had HIV testing? Yes No

Do you have vaginal sex _____ oral sex _____ anal sex _____?

Do you always use condoms? Yes No Sometimes

Do you use dental dams, plastic wrap, or condoms during oral sex? Yes No Sometimes

Please check and circle any specific conditions that apply to you.

	Vaginal infections: yeast, trich, bacterial, or gardnerella		Pelvic surgery
	STDs: Chlamydia, Gonorrhea, Herpes, Venereal Warts/HPV, Syphilis, HIV		Ovarian cysts, fibroids, endometriosis
	Abnormal pap smear: date		Breast implants
	Colposcopy, cervical biopsy		Breast cysts, tumors, nipple discharge
	Cryotherapy		Mammogram
	Laser therapy on cervix		Pain with intercourse

Pregnancy History

Number of pregnancies: _____ Live births: _____ Abortions: _____ Miscarriages: _____

Explanation and dates: _____

Contraceptive History: Please check any birth control methods you or your partner have used.

	Abstinence		Depo Provera		Sponge, foam, suppository
	Condoms		Norplant		Tubal ligation
	Withdrawal		IUD		Vasectomy
	Pills: Which one?		Patch		Nuvaring

What do you use now for birth control? _____

Have you had unprotected sex since your last period? Yes No

Please feel free to discuss any concerns with your clinician that may aid in your care, such as sexuality, relationships, sexual orientation, or physical/sexual abuse.