

**PACIFIC WOMEN'S OBSTETRICS & GYNECOLOGY MEDICAL GROUP**

Today's date \_\_\_\_\_ Your name \_\_\_\_\_ Your age \_\_\_\_\_

**GENERAL GYNECOLOGICAL HISTORY**

Date of last period: \_\_\_\_\_  
Frequency and duration of periods: \_\_\_\_\_  
Do you experience cramps?..... Yes.....No  
If yes, indicate medications used to treat cramps: \_\_\_\_\_  
Age of first period \_\_\_\_\_  
If postmenopausal, have you ever used hormone therapy?..... Yes.....No  
If yes, for how long? \_\_\_\_\_  
Are you currently taking hormone replacement therapy?..... Yes..... No  
If not a current user, when did you stop taking HRT? \_\_\_\_\_

Date of last pap smear \_\_\_\_\_  
Have your pap smears always been normal?..... Yes..... No  
If no: Date of last abnormal pap smear \_\_\_\_\_  
Diagnosis on abnormal pap smear(s) \_\_\_\_\_  
Have you ever been diagnosed with genital herpes or warts(HPV)?......Herpes: Yes No /Warts: Yes No

Total number of pregnancies: \_\_\_\_\_  
Total number of births: \_\_\_\_\_  
Dates of births & indicate if vaginal or c/section: \_\_\_\_\_  
Number of abortions/miscarriages \_\_\_\_\_  
List any pregnancy complications (diabetes, losses, etc) \_\_\_\_\_

Please list all birth control methods you have used: \_\_\_\_\_  
Present method \_\_\_\_\_  
How many total years have you used birth control pills? \_\_\_\_\_

**GENERAL HEALTH HISTORY**

Please list all surgeries \_\_\_\_\_

Please list all medical illnesses \_\_\_\_\_

Please list all drug allergies \_\_\_\_\_  
Please list all current medications (doses, plus vitamins/supplements) \_\_\_\_\_  
Please list dates and reasons for all hospitalizations \_\_\_\_\_

Please list names of all physicians you currently see:  
Primary care physician \_\_\_\_\_ Others \_\_\_\_\_

## GENERAL HEALTH HABITS

Do you smoke? Yes No If yes, how much? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, how much? \_\_\_\_\_

Are you on a special diet? Yes No. If yes, please describe \_\_\_\_\_

Check if you:

\_\_\_\_ exercise regularly \_\_\_\_ wear your seatbelt in the car \_\_\_\_ receive annual flu vaccinations

\_\_\_\_ perform monthly breast self-examination

\_\_\_\_ have received a pneumonia vaccine (pneumovax) within the past 7 years

\_\_\_\_ take recreational drugs and identify how much: \_\_\_\_\_

Have you ever had a sexually transmitted disease (gonorrhea, Chlamydia, warts, HIV, herpes, etc)?

Yes No If yes, which types? \_\_\_\_\_

If you would like to discuss STDs, HIV/AIDS testing, etc., please check here \_\_\_\_\_

Number of lifetime sexual partners \_\_\_\_\_ men women both

Are you sexually active currently? Yes No

Have you or someone close to you ever been sexually or physically abused? Yes No

## FAMILY HEALTH HISTORY

If any family members have had these conditions, please indicate. Include their relationship to you (ie, sister=S, mother=M, daughter=D, paternal aunt=PA, paternal grandmother=PGM, etc) & age at diagnosis:

Breast cancer \_\_\_\_\_ Ovarian/uterine cancer \_\_\_\_\_

Colon cancer \_\_\_\_\_ Osteoporosis/osteoporotic fractures \_\_\_\_\_

Other cancers \_\_\_\_\_ Thyroid disorders \_\_\_\_\_ Diabetes \_\_\_\_\_

Hypertension \_\_\_\_\_ Heart disease \_\_\_\_\_ Stroke \_\_\_\_\_

Thrombophlebitis or pulmonary embolus (blood clot to lung) \_\_\_\_\_

Other family medical problems \_\_\_\_\_

Age of menopause among close female relatives \_\_\_\_\_

## CURRENT HEALTH STATUS

Please check if you are experiencing any of these symptoms currently:

\_\_\_\_ PMS \_\_\_\_ pain with intercourse \_\_\_\_ menopause concerns \_\_\_\_ pelvic pain

\_\_\_\_ urinary loss (incontinence) \_\_\_\_ irregular bleeding \_\_\_\_ sex concerns

Please list other symptoms you currently experience (such as headache, breathing problems, intestinal problems, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SOCIAL HISTORY

Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_

Interests/hobbies/goals \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note any questions you wish to ask the doctor:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_