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 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:
____________________
____________________