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:
_____
_____
_____
_____