

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date: \_\_\_\_\_

### GYN History

Onset of periods (age) \_\_\_\_\_

First day of last menstrual period \_\_\_\_\_

Interval between periods (days) \_\_\_\_\_

Sexually Active? YES NO

Duration of flow (days) \_\_\_\_\_

Method of contraceptive \_\_\_\_\_

Flow: LIGHT MODERATE HEAVY

Date of last pap smear \_\_\_\_\_

Cramps: YES NO

Date of last mammogram \_\_\_\_\_

### Have you ever had any of the following?

abnormal pap smear

chlamydia

HIV

pelvic inflammatory disease

condyloma (venereal warts)

herpes

sexual dysfunction

gonorrhea

incest/rape

painful intercourse

### Obstetrical History: List all pregnancies

### Surgical History

Year	Sex	Weight	Hospital	Complications
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Year	Procedure	Hospital	Complications
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

### Medical History:

Have you been diagnosed with any of the following?

bladder infection

heart disease

hepatitis/liver disease

kidney infection

high cholesterol

varicose veins

urinary tract infection

migraine headaches

blood clots in legs

high blood pressure

diabetes

gastrointestinal disease

asthma/lung disease

seizures

thyroid disease

kidney disease

urinary incontinence

anemia

Current Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Tobacco Use: YES NO If yes, # of cigarettes per day \_\_\_\_\_ Years smoked \_\_\_\_\_

Alcohol Use: YES NO If yes, # of drinks per week \_\_\_\_\_

Illicit Drug Use: YES NO

### Family History

Has any family member ever had any of the following?

diabetes

breast cancer

heart disease

high blood pressure

ovarian cancer

endometriosis

other hereditary disease: \_\_\_\_\_