Gynecological History Form

Name_____ Date (mm/dd/yyyy) _____
(Last name) (First name)
Day Telephone_____ Night Telephone _____ Medical Record Number:_____
(Office use only)

Gynecological and Obstetrical History

First day of your last period (mm/dd/yyyy) _____ Age at first menstruation _____ How long does your period last? _____
How often do your periods occur? (e.g., monthly, every 6 weeks)_____
On the heaviest day, how many pads or tampons do you use? _____ Any cramps? _____
What treatment do you use for cramps? _____
Any PMS symptoms? _____ If so, describe: _____
Do you spot or bleed between periods or after intercourse? _____ If so, describe; _____
Ever Pregnant? _____ If yes, Date(s)_____ Outcome(s) _____
Is this your first GYN exam? _____ Any history of STDs? _____ If yes, which one(s)? _____
Date of last Pap Smear (mm/dd/yyyy) _____ Have you ever had an abnormal Pap Smear? _____ If so, when? _____
Any breast problems? _____ Do you examine your breasts regularly? _____
Have you had a mammogram recently? _____ If yes, Date (mm/dd/yyyy) _____ Outcome_____

Sexual History

Have you had sex with (Check all that apply) ☐Men ☐Women How old were you when you first had sex? _____
Have you had more than one partner in the last year? _____ Do you have any pain with intercourse? _____
If you use contraception, what form(s) do you use? _____ Do you wish to continue with this method?_____
Have you ever experienced sexual assault or incest? _____ Is there violence in any of your relationships? _____

Medical History

Do you have or have you had any medical problems? (Check all that apply):

☐Asthma ☐Diabetes ☐High blood pressure
☐Heart disease ☐Seizure disorder ☐Migraine headaches
☐Gall bladder disease ☐Clotting disorder ☐Abnormal cholesterol
☐Thyroid problems ☐Urinary tract problems

Please describe:_____

Are you taking any medications? _____ Which ones and how often?_____
Any vitamins? _____ Which ones and how often?_____

Surgical History

Have you ever had any surgery (including oral surgery, tonsils, abdominal surgery, etc.)?_____
If yes: Date _____ Type_____ Complications _____
Date _____ Type_____ Complications _____
Date _____ Type_____ Complications _____

Family History

Do your parents or siblings have any of the following? (Check all that apply)

☐High cholesterol ☐Stroke ☐Blood clots
☐Diabetes ☐Breast cancer ☐Liver cancer
☐Heart disease (heart attack) ☐High blood pressure ☐Other

Do any women in your family have a history of (check all that apply):

☐Breast cancer ☐Uterine cancer ☐Ovarian cancer

If yes, who?_____

Social History

Do you smoke tobacco? _____ If yes, how much? _____ How much alcohol do you drink each week? _____
Do you use "recreational" drugs? _____ If yes, which ones? _____

Allergies

Are you allergic to any medicines? _____ Which ones?_____
What is your reaction? _____

Concerns

Do you have concerns about any of the following? (Check all that apply)

☐ AIDS ☐ Safer sex ☐ Sexual assault
☐ Breast self-exam ☐ Contraception ☐ Other health topics