GYN Health History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Name_____ Age: ____ DOB: ___/___/___ Height_____ Date: ___/___/____
List your Primary Care Physician: _____ Last menstrual period: ____/____/_____
Reason for your visit today: _____

List all Allergies & Adverse Reactions

_____
_____
_____

List all Medications/Supplements/Herbal and Dosage

_____
_____
_____
_____
_____
_____
_____

Vaccine Immunization (Flu, Tdap, etc…) & Date received

_____
_____

Past Medical History
Check all diseases and conditions that apply

- ❑ Abuse / Domestic Violence
- ❑ Acne
- ❑ ADHD
- ❑ Allergies (environmental/food)
- ❑ Anemia
- ❑ Anesthesia Complications
- ❑ Anxiety Disorder
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disease
- ❑ Breast Cancer
- ❑ Breast Disease
- ❑ Cancer
- ❑ Cardiovascular Disease
- ❑ Cerebrovascular Accident (Stroke)
- ❑ Colon Polyp
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Ear or Hearing Disorder
- ❑ Eating Disorder
- ❑ Eczema
- ❑ Endocrine Disorder
- ❑ Endometriosis
- ❑ Fibroids
- ❑ Fibromyalgia
- ❑ Gastroesophageal Reflux Disease (GERD)
- ❑ Gastrointestinal Disease
- ❑ Genetic / Hereditary Disorder
- ❑ Genitourinary Disease
- ❑ Heart Disease
- ❑ HIV or AIDS
- ❑ Hepatic / Liver Disease
- ❑ Hypercholesterolemia (high cholesterol)
- ❑ Hypertension (high blood pressure)
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ IBS
- ❑ Immunologic Disorder
- ❑ Menopause
- ❑ Migraines/ Headaches
- ❑ Multiple Sclerosis
- ❑ Neurologic Disorder
- ❑ Obesity
- ❑ Osteoporosis/Osteopenia
- ❑ Ovarian Cancer
- ❑ Ovarian Cyst
- ❑ Polyps
- ❑ Psychiatric Illness
- ❑ Pulmonary / Lung Disease
- ❑ Renal / Kidney Disease
- ❑ Seizures / Epilepsy
- ❑ Skin Disorder
- ❑ Sleep Apnea
- ❑ Substance Abuse/Dependence
- ❑ Thyroid Disease
- ❑ Urologic Disorder
- ❑ Vision / Eye Disorder
- ❑ Vitamin D Deficiency
- ❑ Other_____
- ❑

Past Surgical History
Check all diseases and conditions that apply

- ❑ Appendectomy
- ❑ Back / Spine Surgery
- ❑ Bladder Surgery
- ❑ Breast Biopsy
- ❑ Breast Surgery
- ❑ Caesarean Section
- ❑ Cholecystectomy (gallbladder)
- ❑ Cryosurgery
- ❑ Dermatologic Surgery
- ❑ Dilation and Curettage
- ❑ Ectopic Pregnancy
- ❑ Endometrial Ablation
- ❑ Facial Surgery
- ❑ Gastrointestinal / Colon Surgery
- ❑ Heart Surgery
- ❑ Hysterectomy
- ❑ Hysteroscopy
- ❑ Inguinal Hernia
- ❑ LEEP/ Cone Biopsy
- ❑ Laparoscopy
- ❑ Laparotomy
- ❑ Myomectomy
- ❑ Neurosurgery
- ❑ Oncologic / Cancer Surgery
- ❑ Oophorectomy (ovary removal)
- ❑ Ophthalmologic (eye) Surgery
- ❑ Oral / Dental Surgery
- ❑ Orthopedic Surgery
- ❑ Otolaryngology (ENT) Surgery
- ❑ Ovarian Cystectomy
- ❑ Plastic / Reconstructive Surgery
- ❑ Pulmonary / Lung Surgery
- ❑ Splenectomy
- ❑ Thoracic / Chest Surgery
- ❑ Thyroid Surgery
- ❑ Tonsillectomy
- ❑ Tubal Ligation
- ❑ Vascular Surgery
- ❑ Other _____
  _____
  _____

Gynecology History

1. Date of LMP: ____/____/____
2. Frequency of Cycle: _____
3. Duration of Flow: _____
4. Flow: □ Light □ Moderate □ Heavy
5. Menses Monthly: □ Yes □ No
6. Menstrual Cramps: □ mild □ moderate □ severe
7. Premenstrual Syndrome: □ Yes □ No
8. Date of Last Pap Smear: ____/____/____
9. Date of HPV testing: ____/____/____
10. HPV testing: □ Positive □ Negative
11. Abnormal Pap: □ Yes □ No
12. Abnormal Pap Smear result: _____
    □ ASC-US □ ASC-H □ LSIL □ HSIL □ AGUS
13. Any Treatment for Abnormal Pap? □ Yes □ No
14. Colposcopy: ____/____/____
15. Age at first period: _____
16. If Post-Menopausal, age at menopause _____
17. HPV Vaccine: □ Yes □ No
18. Sexual Orientation:
    □ Heterosexual □ Homosexual □ Bisexual □ Asexual
19. Number of Lifetime Sexual Partners: _____
20. Sexually Active? □ Yes □ No
21. Sexual Problems? □ Yes □ No
22. STIs/STDs: □ Yes □ No
23. Current Birth Control Method:
    □ None □ Condoms □ BCPs □ Depo-Provera □ Patch □ Vaginal Ring □ IUD □ Implant □ Withdrawal □Sterilization □ Tubal Ligation □ Partner Vasectomy □ Abstinence □ Spermicide □ Diaphragm □ Sponge □ Cervical Cap □ Multiple Methods □ Fertility Awareness Method □ Fertility Issues □ Breastfeeding/LAM □ Emergency Contraception □ Pregnant □ Seeking Pregnancy □ Ablation □ Menopause □ Hysterectomy □ Other
24. Desired Birth Control Method: _____
25. Date of Last Mammogram: ____/____/____
26. Mammogram Result: □ Normal □ Abnormal
27. Most Recent Bone Density: ____/____/____
28. Date of Last Colonoscopy: ____/____/____
29. Endometriosis: □ Yes □ No
30. Fibroids: □ Yes □ No
31. Infertility: □ Yes □ No
32. Ovarian Cyst: □ Yes □ No
33. PCOS: □ Yes □ No

Family History

Check all diseases and conditions that apply and list family member **(M**-Mother, **F**-Father, **Son**-Son, **D**-Daughter, **S**-Sister, **B**-Brother, **MGM**-Maternal, Grandmother, **MGF**-Maternal Grandfather, **MA**-Maternal Aunt, **MU**- Maternal Uncle, **O**-Other Relative, **PGM**-Paternal Grandmother, **PGF**-Paternal Grandfather, **PA**- Paternal Aunt, **PU**-Paternal Uncle**)**

- ❑ Addiction _____
- ❑ Anemia _____
- ❑ Anxiety disorder _____
- ❑ Arthritis _____
- ❑ Asthma _____
- ❑ Blood coagulation disorder _____
- ❑ Cerebrovascular accident/ **Stroke** _____
- ❑ COPD _____
- ❑ Cystic fibrosis _____
- ❑ Depressive disorder _____
- ❑ Developmental disorder_____
- ❑ Diabetes mellitus _____
- ❑ Disease of liver _____
- ❑ Disorder of cardiovascular system _____
- ❑ Disorder of endocrine system _____
- ❑ Disorder of gastrointestinal tract _____
- ❑ Disorder of lung _____
- ❑ Disorder of nervous system _____
- ❑ Disorder of the genitourinary system _____
- ❑ Disorder of thyroid gland _____
- ❑ Heart Disease _____
- ❑ Heart failure _____
- ❑ High Cholesterol _____
- ❑ High Blood Pressure _____
- ❑ Immunodeficiency disorder _____
- ❑ Kidney disease _____
- ❑ Uterine cancer _____
- ❑ Other Cancer _____
- ❑ Breast Cancer _____
- ❑ Cervical Cancer _____
- ❑ Colon Cancer _____
- ❑ Lung Cancer _____
- ❑ Ovarian cancer _____
- ❑ Stomach cancer _____
- ❑ Mental disorder _____
- ❑ Migraine/ Headaches _____
- ❑ Multiple sclerosis _____
- ❑ Myocardial infarction/ **heart attack** _____
- ❑ Obesity _____
- ❑ Osteoporosis _____
- ❑ Rheumatoid arthritis _____
- ❑ Seizure _____
- ❑ Tuberculosis _____

Social History

1. Chewing tobacco: □ None □ 1/day □ 2-4/day □ 5+/day
2. Tobacco Smoking Status: □ Never smoker □ Former smoker □ Current every day smoker □ Current some day smoker

   □ Smoker - status unknown □ Unknown if ever smoker
3. Smoking - How much? □ None □ 1 PPW □ 2 PPW □ 1/4 PPD □ 1/2 PPD □ 1 PPD □ 1 1/2 PPD □ 2 PPD □ 3+ PPD
4. Smokeless tobacco status: □ Never used smokeless tobacco □ Former smokeless tobacco user □ Current snuff user □Currently chews tobacco □ Currently uses moist powdered tobacco
5. Tobacco- years of use: _____
6. E-cigarettes/ vape status: □ Never used electronic cigarettes □ Former user of electronic cigarettes □ Current user of electronic cigarettes
7. Do you have an Advance directive to guide your healthcare in the event you are unable to make decisions? □ Yes □ No
8. Marital status: □ Unknown □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner
9. Do you feel safe in your current relationship? □ Yes □ No
10. Sexual orientation?

    □ Lesbian/ gay/ homosexual □ Straight/ heterosexual

    □ Bisexual □ Something else □ Don't know

    □ Choose not to disclose
11. Number of children: _____
12. Are you working: □ Yes □ No □ Retired □ Disabled
13. Occupation: _____
14. On average, how many days per week do you engage in moderate to strenuous EXERCISE (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)? _____
15. On those days, how many minutes, on average, do you engage in EXERCISE at this level? _____
16. How often do you have a DRINK containing ALCOHOL?

    □ Never □ Monthly or less □ 2-4 times a month

    □ 2-3 times a week □ 4 or more times a week
17. How many standard DRINKS containing alcohol do you have on a typical day? □ 1 or 2 □ 3 or 4 □ 5 or 6

    □ 7 to 9 □ 10 or more
18. How often do you have six or more DRINKS on one occasion? □ Never □ Less than monthly □ Monthly

    □ Weekly □ Daily or almost daily
19. Illicit drugs: _____
20. Do you have symptoms associated with Zika virus (fever, rash, joint pain, or conjunctivitis)? □ Yes □ No
21. Is blood transfusion acceptable in an emergency?

    □ Yes □ No

Obstetric History

Have you ever been pregnant? □Yes □No

How many times have you been pregnant? _____

Full Term_____ Premature_____ Miscarriages_____ Abortions_____ Ectopic_____ Multiples_____ Living children_____

Date	# Fetuses	Gestational age	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia	Complications
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		