Arrowhead Women's Center

Name: _____ Age: _____ Date of Birth: _____ Date: _____

Reason for today's visit: _____

GYNECOLOGICAL HISTORY

When was your last pap smear? _____ Have you ever had an abnormal pap smear? ☐ Yes ☐ No

When was your last mammogram? _____ When was your last menstrual period? _____

Are your periods regular? ☐ Yes ☐ No How long do they last? _____ Birth control method: _____

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If so, what and when?_____

Any GYN problems? (irregular menses, painful intercourse, etc.)_____

List any known allergies to medications and their effects: _____

List any medications you are taking:_____

_____

MEDICAL HISTORY

Any Significant past medical history/diagnosis: _____

_____

PREGNANCY HISTORY

Total number of pregnancies: _____ Total number of live births: _____ Number of miscarriages: _____

Number of abortions: _____ How many vaginal deliveries? _____ How many C-sections? _____

Any pregnancy complications? _____

Ages of children: _____

SURGICAL HISTORY

Previous surgeries (include year performed to the best of your recollection):_____

_____

_____

FAMILY HISTORY

Do any of your relatives have/had any of the following (circle any that apply):

(a) Breast cancer (b) Cervical cancer (c) Uterine cancer (d) Ovarian cancer (e) Colon cancer

If you circled any of the above, how are you related to that person?_____

_____

SOCIAL HISTORY

What is your marital status? (Please circle one) Single / Married / Divorced / Partnered / Widowed / Other

Do you smoke? ☐ Yes ☐ No If so, how much? _____ If no, have you ever smoked? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how often and how much? _____

Do you use drugs? ☐ Yes ☐ No If yes, what type?_____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how much?_____