GYNECOLOGICAL HISTORY

NAME: _____ AGE: _____ DATE: _____

PLEASE LIST BELOW THE REASON FOR YOUR APPOINTMENT AND DURATION OF SYMPTOMS:

_____

_____

_____

_____

When was your last Pap Smear:_____

Where?_____

Have you ever had an abnormal Pap Smear?

No [ ] Yes [ ] If yes, what was the diagnosis?

_____

When was your last Mammogram?_____

Where?_____

Last Menstrual Period?_____

Pain during period? Y [ ] N [ ]

Bleeding between periods? Y [ ] N [ ]

Pain with intercourse? Y [ ] N [ ]

Feeling of pelvis falling? Y [ ] N [ ]

Urinary urgency/frequency? Y [ ] N [ ]

Menopausal symptoms? Y [ ] N [ ]

Loss of urine? Y [ ] N [ ]

List all known allergies to medications and their effects:

_____

_____

_____

_____

What is the time interval between the start of one period and the next? (26-28 days, etc.) _____

How many days do they last?_____

Total number of pregnancies:_____

Total number of live births:_____

Total number of miscarriages:_____

Total number of abortions:_____

Complications:_____

_____

Have you experienced clotting problems with surgery?

Please explain:_____

_____

Please list any medications you are currently taking, including over the counter medications:_____

_____

_____

_____

_____

SURGICAL HISTORY

	YEAR:	TYPE OF SURGERY/OPERATION/PROCEDURE:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

PAST ILLNESS

YES	NO		YEAR	YES	NO		YEAR
[ ]	[ ]	Childhood Diseases	_____	[ ]	[ ]	Mental Disease	_____
[ ]	[ ]	Poliomyelitis	_____	[ ]	[ ]	Venereal Disease	_____
[ ]	[ ]	Rheumatic Fever	_____	[ ]	[ ]	Diabetes	_____
[ ]	[ ]	Hepatitis	_____	[ ]	[ ]	Thyroid Disease	_____
[ ]	[ ]	Tuberculosis	_____	[ ]	[ ]	Blood Transfusions	_____
[ ]	[ ]	Blood Disease	_____	[ ]	[ ]	High Blood Pressure	_____
[ ]	[ ]	Heart Disease	_____	[ ]	[ ]	Varicose Veins	_____
[ ]	[ ]	Kidney Infections	_____	[ ]	[ ]	Phlebitis	_____
[ ]	[ ]	Bladder Infections	_____	[ ]	[ ]	Others	_____
[ ]	[ ]	Epilepsy	_____			_____	

FAMILY HISTORY

Have your grandparents, parents, brothers, sisters, aunts, or children had/have:

YES	NO		YEAR	YES	NO		YEAR
[ ]	[ ]	Cancer	_____	[ ]	[ ]	Epilepsy	_____
[ ]	[ ]	Diabetes	_____	[ ]	[ ]	Nervous Breakdown	_____
[ ]	[ ]	Tuberculosis	_____	[ ]	[ ]	Glaucoma	_____
[ ]	[ ]	Heart Disease	_____	[ ]	[ ]	Severe Deafness	_____
[ ]	[ ]	Kidney Disease	_____	[ ]	[ ]	Blood Disease	_____
[ ]	[ ]	High Blood Pressure	_____	[ ]	[ ]	Nervous Disorders	_____
[ ]	[ ]	Hay Fever/Asthma	_____	[ ]	[ ]	Muscular Disorders	_____
[ ]	[ ]	History of Twins	_____	[ ]	[ ]	Birth Defects	_____

Father's Age:_____ If deceased, cause of death:_____

Mother's Age:_____ If deceased, cause of death:_____

SOCIAL HISTORY

Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

Married more than once?	[ ] Yes [ ] No	How many times?_____ Years married?_____
Do you smoke?	[ ] Yes [ ] No	How many packs per day?_____
Do you drink alcohol?	[ ] Yes [ ] No	How often?_____
Do you use drugs?	[ ] Yes [ ] No	How often?_____