



NAME: _____ DATE: _____

Please answer these questions about your previous and current health. Your health care provider will review these with you.

REASON FOR VISIT: _____

REFERRED BY: _____

WHO IS YOUR GENERAL PHYSICIAN? (*internist, family practitioner,CP*): _____

PAST GYNECOLOGICAL HISTORY (*Please check off any conditions that you have had and give dates if appropriate*)

GYNECOLOGICAL ILLNESS	YES	NO	DATE	GYNECOLOGICAL ILLNESS	YES	NO	DATE
Pelvic Inflammatory Disease				Human Papilloma Virus (HPV)			
Ovarian Cyst				Herpes			
Uterine Fibroids				Other Sexually Transmitted Diseases			
Endometriosis				Abnormal PAP Smears			
Breast Disease				Other			
Fertility Problems				Other			

MENSTRUAL HISTORY

Age at first Menses: _____ If Menopausal, age at last Menses: _____

Usual Interval Between Periods (*1st day to 1st day*): _____

Last Menstrual Period: _____ Usual Days of Bleeding with Each Period: _____

Cramping with Period: _____

Need for Pain Medication (*please list*): _____

Bleeding Between Periods: _____ Do You Experience PMS? _____

MISCARRIAGE(S)

TERMINATION(S) (*please list date*)



NAME: _____ DATE: _____

USE OF CONTRACEPTION *(Please list present and past)*

	PRESENT	PAST		PRESENT	PAST
Oral Birth Control Pills			IUD		
Cervical Cap			Norplant		
Diaphragm			Depo-provera		
Condoms			Other:		

SEXUAL HISTORY / ORIENTATION

Have you ever experienced rape, incest, domestic violence or sexual abuse? _____

PREGNANCIES:

YEAR	TYPE OF DELIVERY	BIRTH WEIGHT OF INFANT	COMPLICATIONS

PAST SURGICAL PROCEDURES *(Including non-gynecologic)*

YEAR	PROCEDURE	COMPLICATIONS

PAST MEDICAL PROBLEMS *(Please check any that you have had and give dates if appropriate)*

PAST MEDICAL PROBLEM	YES	NO	DATE	PAST MEDICAL PROBLEM	YES	NO	DATE
Rheumatic Fever				Osteoporosis			
Asthma				Hepatitis			
Epilepsy				High Blood Pressure			
Heart Disease				Bleeding Disorder			
Mitral Valve Prolapse				Anemia			
Tuberculosis				Diabetes			
Eating Disorder:				Gastrointestinal Problems			
Bulimia				High Cholesterol			
Anorexia				Depression			
Kidney Infection				Other Psychological Problems			
Thyroid Abnormalities				Other			
Seasonal Allergies				Other			



NAME: _____ DATE: _____

MEDICATION (Please list any prescription or over-the-counter medications or vitamins that you are taking)

MEDICATION	DOSAGE

ALLERGIES TO MEDICATIONS (Please check if you have any of the listed allergies and list any other medications you are allergic to)

Penicillin Iodine Sulfa Medications Latex Other: _____ Other: _____

DIET HABITS

Are you on a restricted diet? (i.e. vegetarian, low cholesterol, etc.): _____

Do you smoke? _____ How many packs a day? _____

How many alcoholic drinks per week? _____ Other drug use? _____

EXERCISE

Do you engage in regular exercise? (please describe): _____

FAMILY HISTORY (Do/Did any family members have any of the following? Please check appropriate responses)

Breast Cancer Colon Cancer Ovarian Cancer Uterine Cancer
 Osteoporosis Hypertension Bleeding Disorders Heart Disease (prior to age 65 [women] & 55 [men])

Please list any other Health Information that you would like to discuss: _____

