Gynecological History Form

Name:_____D.O.B._____Date:_____
Current concerns:_____
_____
_____

Date of last annual gynecological exam and Pap smear?_____
Any difficulties with these exams?_____
Age of onset of menses?_____
First day of last menstrual period?_____
Was it normal?_____
What is normal for you?_____
Number of days between day 1 of one period and day one of next period?_____
Any problems? (PMS, pain, heavy bleeding, irregularity, spotting)_____
_____
Any menopausal symptoms?_____
Regular self breast exam?_____
Sexual partners are men, women, both, or none?_____
Pain with sexual activity?_____
Number of male partners ever?_____
Age of first intercourse with males?_____

Birth control and medication history
Form of birth control currently using?_____
Any problems?_____
Forms used in past? (birth control pill, IUD, diaphram, cervical cap, condom, other) and problems you had with them_____
Any hormonal medication used? (HRT, DES, steroids, cortisone, prednisone, thyroid medication, other)_____
Other current medications?_____

Pregnancy history
Please indicate dates of the following
Pregnancies_____
Births_____Miscarriages_____
Abortions_____Tubal/ectopic_____
Any difficulties conceiving?_____
Any complications of pregnancy? (hemorrhage, infection, Cesarean birth, toxemia, blood sugar or blood pressure problems) _____
_____
Did you breastfeed? How many months?_____

Medical History
Cancers_____
Thyroid problems_____
Anemia_____
Diabetes_____
Dental problems_____
Fractures_____
Hospitalization_____
Period of immobilization_____
Abnormal Pap smear_____
Breast lump/tumor_____
Nipple discharge_____
Bladder infections_____
Bleeding/clotting problems_____
STI's (chlamydia, gonorrhea, syphilis, herpes, veneral warts, pelvic inflammatory disease)_____
Vaginal infections_____
Uterine/cervical difficulties_____
Ovarian cysts/tumors_____
Uterine fibroids/endometriosis_____

Family Medical History
Has anyone in your family been diagnosed with these conditions? Indicate their age at which they were diagnosed.
Heart disease_____
Cancer/type_____
Osteoporosis_____

Lifestyle
Please indicate past and present use

Tobacco_____
Alcohol consumption_____
Caffeine consumption_____
Carbonated beverages_____
Amount of exercise_____
Diet_____