

## MEDICAL HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Please explain what concerns brought you to here? \_\_\_\_\_  
\_\_\_\_\_

### Gynecologic History

#### I. Menstrual Cycle

What was the first day of your last menstrual period?	
Have you gone through menopause?	Yes No
If yes, at what age?	Age
How many days does your period last?	_____ days
How often do you get your period?	Every _____ days
How would you describe the flow of your period?	light normal heavy
Do you have cramping or pain with your period?	Yes No
If yes, how would you rate your pain with 10 being the worst?	1 2 3 4 5 6 7 8 9 10

#### II. Childbirth and Sexual Activity

Have you ever been pregnant?	Yes No
Number of pregnancies	
Number of miscarriages	
Number of abortions	
Have you ever given birth to a child?	Yes No
Number of vaginal births	
Number of cesarean sections	
Are you sexually active?	Yes No
Do you have pain with intercourse?	Yes No
If yes, how would you rate your pain with 10 being the worst?	1 2 3 4 5 6 7 8 9 10
If you have ever had a sexually transmitted infection indicate which one/ones (HPV, HIV, herpes, chlamydia, gonorrhea, genital warts)	Other:
What form of contraception do you use?	

#### III. Bladder and Bowel Health

Do you have problems with urinary incontinence (inability to control urination)?	Yes No
Do you have problems with stool incontinence (inability to control bowel movements)?	Yes No

#### III. Breast Health

Have you ever had a mammogram?	Yes No
If yes, when was your last exam?	
Have you ever has an abnormal mammogram?	Yes No
If yes, what was the date, result and treatment?	

**IV. Cervical, Uterine and Ovarian Health**

When was your last Pap smear?		
Have you ever had an abnormal Pap smear?	Yes	No
If yes, what was the date, result and treatment?		
Have you ever had a pelvic ultrasound?	Yes	No
If yes, what was the date, result and treatment?		
Have you ever had an endometrial biopsy?(sampling of the uterine lining)	Yes	No
If yes, what was the date and result?		
Please explain if you have any issues regarding your ovaries		

**Your Medical and Family History**

Check any past or current medical problems for yourself or your immediate blood relatives.

X = Yourself, M = Mother, F = Father, S = Sister, B = Brother, Maternal Grandmother/grandfather = MGM/MGF

Paternal Grandmother/grandfather = PGM/PGF

Medical Problem	You	Family	Please Explain
Abuse (emotional, physical, sexual)			
Anemia			
Asthma/Lung disease			
Autoimmune disorder (Chrons's, Lupus, RA, etc)			
Arthritis			
Bleeding disorder			
Cancer (breast, colon, ovarian, uterine, cervix, other)			
Blood clotting disorder (blood clots in legs/lungs)			
Diabetes			
Elevated cholesterol			
Fibromyalgia/chronic pain			
Depression/anxiety/eating disorder/psychiatric illness			
Gastrointestinal disease (gallbladder, bowel, stomach, etc)			
Heart disease			
Kidney disease (stone, bladder/kidney infections, etc)			
Hypertension (high blood pressure)			
Liver disease/hepatitis			
Neurologic disease (seizure, migraine, stroke, etc)			
Osteoporosis			
Skin disorder			
Thyroid or other glandular disorder			
<b>Other:</b>			

**Adverse Drug Reactions and Drug Allergies**

Are you allergic to or have any adverse reactions to any medications?    Yes    No  
 If yes, please list the medications and the adverse reaction that occurs.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Surgical & Hospitalization History**

Type of surgery or reason for hospitalization	Date of surgery or hospitalization	If you had complications, please explain

**Current Medications**

Please list your medications, including birth control, vitamins & herbs.

Medication	Dosage	Medication	Dosage
1)		8)	
2)		9)	
3)		10)	
4)		11)	
5)		12)	
6)		13)	
7)		14)	

**Social History**

Do you exercise regularly?    Yes    No  
 How often do you exercise? \_\_\_\_\_ minutes \_\_\_\_\_ x per week  
 What activities do you perform? \_\_\_\_\_

Smoking status                      Non-smoker  
     Current smoker  
     how much do you smoke? \_\_\_\_\_ packs/day  
     Smoked in the past