GYN Medical History

Last Name First Name DOB

Medical □ None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc)_____
_____
_____
_____
_____

Pregnancy History

Year	Sex	Complications
____	___	_____
____	___	_____
____	___	_____
____	___	_____

Surgical □ None Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)_____
_____
_____
_____
_____
_____
_____

Gyn/Breast/Colon History
Last Pap:_____
Last Mammo:_____
Colonoscopy:_____
Sigmoidoscopy:_____
Regular Periods?_____
Length of Periods?_____
Age at 1st Period?_____
History of abnormal paps _____

Allergies to Medications? □ None (If yes, please explain type of reaction, i.e. hives,wheezing, upset stomach, swelling etc.)
_____
_____
_____

Current Prescription Medicines □ None

Name of Drug	mg dose	# tablets	# times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Prescription Medicines (cont'd)

Name of Drug	mg dose	# tablets	# times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

	Living	Deceased	Illness	Cause of death/illness
Father	□	□	_____	_____
Mother	□	□	_____	_____
Sister (s)	□	□	_____	_____
Brother (s)	□	□	_____	_____

Other Family History:	Yes	No	Family Member		Yes	No	Family Member
Heart Disease	□	□	_____	Osteoporosis	□	□	_____
Cancer (type)	□	□	_____	Thyroid Problems	□	□	_____
Diabetes	□	□	_____	Endometriosis	□	□	_____
Alcohol Abuse	□	□	_____	Other	□	□	_____

Social History

Smoke? □ Yes □ No If yes, # of packs per day:_____ # of years_____ When did you stop smoking?_____
Alcohol? □ Yes □ No If yes, how many drinks per week? _____
Occupation?_____
□ Coffee – How Much?_____ □ Tea – How Much? _____ □ Soda – How Much?_____
Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when:
_____
Domestic Violence?
_____

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name_____First Name_____DOB_____
Date_____

Review of Systems

Do you now or have you had any problems related to the following systems? **(Please Use Black Ink)**
Circle Yes or No

Constitutional Symptoms		**Comments**	**Musculoskeletal**		**Comments**
Weight change	Y N		Bone Pain	Y N	
Chills/Fever	Y N		Muscle Pain	Y N	
Sleep Disorder	Y N		Joint Pain	Y N	
Eyes			**Integumentary (skin)**		
Double Vision	Y N		Rash	Y N	
Glaucoma	Y N		Lumps or Bumps	Y N	
Cataracts	Y N		Moles, Skin Tags	Y N	
Ear/Nose/Throat/Mouth			**Respiratory**		
Hearing Changes	Y N		Wheezing	Y N	
Sore Throat	Y N		Frequent cough	Y N	
Sinus Problems	Y N		Shortness of Breath	Y N	
Cardiovascular			**Neurological**		
Chest Pain	Y N		Tremors	Y N	
Irregular Heartbeat	Y N		Dizzy Spells	Y N	
Swelling in Ankles	Y N		Numbness/Tingling	Y N	
Psychological			**Gastrointestinal**		
Are You generally happy?	Y N		Abdominal Pain	Y N	
Do you feel depressed?	Y N		Nausea/Vomiting	Y N	
Do you feel anxious?	Y N		Indigestion/Heartburn	Y N	
Do you feel safe in your home?	Y N		Constipation/Diarrhea	Y N	
			Other:		
Endocrine			**Genitourinary**		
Excessive Thirst	Y N		Urinary Incontinence (loss of urine)	Y N	
Too Hot/Cold	Y N		* Spontaneous	Y N	
Tired/Fatigued	Y N		* With Activity	Y N	
Irregular Periods	Y N		Urinary Frequency > 8 times/day	Y N	
Painful Periods	Y N		Painful Urination	Y N	
Heavy Bleeding	Y N				
Bleeding after Menopause	Y N				
Hematologic/Lymphatic			**Sexual History**		
Swollen Glands	Y N		Have you ever been sexually active?	Y N	
Blood Clotting Problems	Y N		Are you currently sexually active?	Y N	
Bruising	Y N		Heterosexual or Homosexual (circle one)		
			Method of Contraception _____		
			Change in Sex Drive	Y N	
			Painful Intercourse Sexual Trauma	Y N	
Allergic/Immunologic	Y N				
Hay Fever	Y N		Are you done having children?	Y N	
			Have you had a Gardisil injection?	Y N	
Drug Allergies	Y N		Have you been vaccinated for:		
Food allergies	Y N		Tetanus, Diptheria, Pertussis (Tdap)	Y N	
Other:			Hepatitis A	Y N	
			Hepatitis B	Y N	

Physician Signature _____Date_____