



What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: \_\_\_\_\_

### OB HISTORY

1. How many times have you been pregnant? .....
2. How many miscarriages have you had? .....
3. How many abortions have you had? .....
4. Have you had any Tubal/Ectopic pregnancies? .....
5. How many vaginal deliveries have you had?.....
6. How many Cesarean Sections have you had?.....
7. Have you had any premature deliveries? .....
8. Have you had any babies weighing less than 5 lb 8 oz at birth? .....
9. How many full term deliveries? .....
10. Have you had any twin births? .....
11. Did you have any complications with your pregnancies?  YES  NO  
If yes, list: \_\_\_\_\_

### GYN HISTORY

1. Are you sexually active?  YES  NO
- 1a. Have you been sexually active?  YES  NO
2. Do you have pain with intercourse?  YES  NO
3. What type of contraception are you currently using? (CIRCLE BELOW)  
Pills      Tubal Ligation      Condoms      Withdrawal      Depo Provera      IUD  
Foam      Vasectomy      Diaphragm      Implants      Other \_\_\_\_\_
4. What type of contraception have you used in the past? (CIRCLE BELOW)  
Pills      Tubal Ligation      Condoms      Withdrawal      Depo Provera      IUD  
Foam      Vasectomy      Diaphragm      Implants      Other \_\_\_\_\_
5. Are you having any problems with your method of Birth Control?  YES  NO
6. Have you ever had any vaginal, cervical and/or tubal infection?  YES  NO  
If yes, please check below:  
 Yeast     Gardnerella     Syphilis     Condyloma     Bacterial Vaginitis     PID  
 Herpes     Trichomonas     Chlamydia     Gonorrhea     Warts     Other \_\_\_\_\_
7. Date of last pap smear? \_\_\_\_\_
8. Have you ever had an abnormal pap smear?  YES  NO  
If yes, how was it treated? Please check below:  
 Repeated Pap Smear     Colposcopy     Laser Surgery     Cone Biopsy  
 Cryosurgery (freezing)     Hysterectomy     Loop Excision
9. Do you have trouble leaking urine?  YES  NO

10. Do you have any breast lumps, tenderness or discharge?  YES  NO
- 10a. Have you had a mammogram?  YES  NO  
 If yes, was it normal?  YES  NO  
 Date of last mammogram \_\_\_\_\_
11. Do you do breast self exams?  YES  NO
12. Do you have PMS symptoms?  YES  NO  
 If yes, any treatment? \_\_\_\_\_
13. Do you have any hot flashes or menopausal symptoms?  YES  NO
14. Do you have any uterine anomalies?  YES  NO
15. Do you have a history of infertility?  YES  NO
16. Do you have a history of DES exposure?  YES  NO

### MENSTRUAL HISTORY

1. If you no longer have periods, please state reason: \_\_\_\_\_
2. First day of last period: \_\_\_\_\_
3. How many days does your period last? \_\_\_\_\_
4. Are your periods regular?  YES  NO
5. How many days from the start of one period to the start of the next period? \_\_\_\_\_
6. Has the flow changed in any way? \_\_\_\_\_ If so, how? \_\_\_\_\_
7. Do you have any bleeding between periods?  YES  NO
8. Do you have any cramping with your periods?  YES  NO  
 If yes, circle one: mild                      moderate                      severe
9. Medicine taken for cramps? \_\_\_\_\_

### SOCIAL HISTORY

1. Do you smoke cigarettes?  YES  NO  
 If yes, # per day? \_\_\_\_\_ Number of years? \_\_\_\_\_
2. Do you use street drugs?  YES  NO
3. Do you drink alcohol?  YES  NO  
 If yes, how much per day? \_\_\_\_\_

## PAST MEDICAL HISTORY

1. Do you have diabetes?  YES  NO
2. Do you have/had hypertension?  YES  NO
3. Do you have heart disease?  YES  NO
4. Do you have a heart murmur?  YES  NO
5. Do you have/had kidney disease?  YES  NO
6. Have you ever been treated for psychiatric problems?  YES  NO
7. Have you ever had rheumatic fever?  YES  NO
8. Do you have mitral valve prolapse?  YES  NO
9. Have you ever had a urinary tract infection?  YES  NO
10. Have you ever had hepatitis/liver disease?  YES  NO
11. Have you ever had varicosities/phlebitis?  YES  NO
12. Do you have any thyroid problems?  YES  NO
13. Have you had any major accidents?  YES  NO
14. Have you ever had any blood transfusions?  YES  NO
15. Do you have asthma/lung disease?  YES  NO
16. Do you have any Drug Allergies?  YES  NO

If yes, please list: \_\_\_\_\_

17. Please list any GYN surgeries: \_\_\_\_\_

18. Please list any other operations/hospitalizations (include year & reason): \_\_\_\_\_

19. Have you had any anesthesia complications?  YES  NO

If yes, please list: \_\_\_\_\_

20. Have you ever been anemic?  YES  NO

21. Do you have an Internist or Family doctor?  YES  NO

Please list name, phone number: \_\_\_\_\_

22. Are you currently on any medications?  YES  NO

If yes, please list with dosage: \_\_\_\_\_

23. Have you had your cholesterol checked?  YES  NO

If yes, date last checked: \_\_\_\_\_

Was it normal?  YES  NO

24. Do you have Arthritis?  YES  NO

If yes, what type? \_\_\_\_\_

25. Do you have Lupus, Scleroderma or similar diseases?  YES  NO

If yes, please describe: \_\_\_\_\_

## FAMILY HISTORY

1. Do you have a family history of breast cancer?  YES  NO  
If yes, whom? \_\_\_\_\_
2. Do you have a family history of colon cancer?  YES  NO  
If yes, whom? \_\_\_\_\_
3. Do you have a family history of ovarian cancer?  YES  NO  
If yes, whom? \_\_\_\_\_
4. Do you have a family history of osteoporosis?  YES  NO  
If yes, whom? \_\_\_\_\_
5. Do you have a family history of diabetes?  YES  NO  
If yes, whom? \_\_\_\_\_
6. Do you have a family history of hypertension?  YES  NO  
If yes, whom? \_\_\_\_\_
7. Do you have a family history of heart disease?  YES  NO  
If yes, whom? \_\_\_\_\_
8. Do you have a family history of kidney disease?  YES  NO  
If yes, whom? \_\_\_\_\_