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GYNECOLOGY HEALTH HISTORY

DATE: ____/____/____ PATIENT NAME: _____ AGE _____

RACE: _____ OCCUPATION: _____ REFERRING PHYSICIAN: _____

MARITAL STATUS: _____ PHARMACY: _____ PCP: _____

Past Medical, Family & Social History

(x) ABNORMAL	PERSONAL	FAMILY
WEIGHT LOSS	☐	☐
APPETITE	☐	☐
HEADACHE/MIGRAINE	☐	☐
HEART DIS (MVP OR RHD)	☐	☐
HYPERTENSION	☐	☐
RESPIRATORY DISEASE	☐	☐
JAUNDICE/HEPATITIS	☐	☐
GALL BLADDER DISEASE	☐	☐
H. HERNIA/PEPTIC ULCER	☐	☐
BOWEL DISORDERS	☐	☐
KIDNEY DISEASE	☐	☐
URINARY INCONTINENCE	☐	☐
URINARY INFECTIONS	☐	☐
ANEMIA/BLOOD DISORDER	☐	☐
BLOOD TRANSFUSIONS	☐	☐
VARICOSE VEINS/PHLEBITIS	☐	☐
SKIN DISEASE	☐	☐
DIABETES	☐	☐
NIGHT SWEATS	☐	☐
THYROID DISEASE	☐	☐
CANCER	☐	☐
EPILEPSY/NEURO DISORDER	☐	☐
ARTHRITIS	☐	☐

MEDICATIONS CURRENTLY TAKING

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

DRUG ALLERGIES: Please explain:

HABITS:

SMOKER: _____ CIG/DAY/YR ALCOHOL: _____ OZ/WK

ILLICIT DRUGS: _____

HOSPITALIZATIONS:

ILLNESSES/OPERATION	MO/YR	ILLNESSES/OPERATION	MO/YR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SEXUAL HISTORY: ☐ SATISFACTORY ☐ UNCOMFORTABLE ☐ WISH TO DISCUSS NUMBER OF PARTNERS _____

OBSTETRICAL HISTORY
(# OF TIME) PREGNANT

PREMATURE
BABIES MISCARRIAGES ABORTIONS LIVING CHILDREN

MENSTRUAL HISTORY AGE AT FIRST PERIOD _____ DATE OF LAST PERIOD (1ST DAY) _____

PERIOD INTERVAL
(1ST DAY TO 1ST DAY) # DAYS _____ DURATION OF BLEEDING _____ CRAMPS Y____ N____ MILD MOD SEVERE
ALWAYS PRESENT Y____ N____

CRAMPS START BEFORE____ DURING____ AFTER____ BLEEDING MEDICATIONS FOR CRAMPS? Y____ N____ TYPE? _____

HOW MANY PERIODS IN LAST YEAR? _____ BLEEDING (SPOTTING) BETWEEN PERIODS? Y____ N____

VAGINAL INFECTIONS — HISTORY OF ☐ YEAST ☐ TRICHOMONAS ☐ CHLAMYDIA ☐ HERPES ☐ GONNORHEA

DATE OF LAST PAP TEST _____ ☐ NORMAL ☐ ABNORMAL

DATE OF LAST MAMMOGRAM _____ ☐ NORMAL ☐ ABNORMAL

Physician Signature: _____ **Date:** _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other _____

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N

Other _____

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other _____

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other _____

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other _____

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N

Other _____

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other _____

Hemotological/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem	Y	N

Other _____

Psychological

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Physician use only: (Comments/Notes)_____

_____

_____

Physician Signature: _____ **Date:** _____