GYN HISTORY
(Information is confidential)

PLEASE COMPLETE BOTH SIDES OF FORM

Today’s Date: ____________________________ First day of last normal period: ____________________________

At what age did your periods start? ____________________________ Are your periods regular? Yes No

On the average, how many days do you usually flow? _________ Is the flow (circle): Light Moderate Heavy

Date of last Pap Smear: ____________________________ Place/Facility: ____________________________

Any Abnormal Pap Smears? No Yes If yes, date: ____________________________ Place/Facility: ____________________________

Ever had a Mammogram? No Yes If yes, date: ____________________________ Any abnormal results? No Yes If yes, date: ____________________________

Breast Implants? No Yes If yes, date: ____________________________ Any problems? No Yes If yes, explain: ____________________________

Sexually Active? No Yes If yes, circle as applicable: Oral Vaginal Anal

Date of last sexual contact: ____________________________ Was this contact protected? Yes No

Partner(s): Male Female # of partners past 3 mos.: ______ # of lifetime partners: ______ Age first sexual intercourse: ______

Current method of contraception: ____________________________ Use of condoms (circle): Always Occasionally Never

Are you concerned you may be pregnant? No Yes Number of Pregnancies: ______ Deliveries: ______ Abortions: ______ Miscarriages: ______

Gynecological surgery? No Yes If yes, list: ____________________________

Methods of Contraceptives you have used in the past (circle):

Cervical Cap Condoms Depo Provera
Diaphragm IUD Norplant
Oral Contraceptives (BCP) Ortho Evra Patch Nuva Ring
Spermicide Sponge Rhythm/Fertility Method
Withdrawal Other: ____________________________

None of the above

Problems Experienced:

Past/Current GYN Conditions (circle as applicable):

Bacterial Vaginosis (Gardnerella) Genital Warts (HPV) Pelvic Inflammatory Disease (PID)

Problems Experienced:

Bleeding Between Periods Gonorrhea Severe Menstrual Cramps

Problems Experienced:

Breast Problems Herpes (HSV) Syphilis

Problems Experienced:

Chlamydia Nonspecific Vaginitis Trichomonas

Problems Experienced:

DES Exposure Ovarian Disease Yeast

Problems Experienced:

None of the above

OVER

PLEASE CONTINUE ON REVERSE SIDE

OVER
GENERAL MEDICAL HISTORY (circle as applicable):
Anemia (Iron-deficiency)  Depression  Headaches (Migraine/Recurrent/Tension)
Blood clot in legs/lungs  Eating Disorders  High Blood Pressure
Urinary Tract Infections (Frequent)  None

FAMILY HISTORY - Indicate relationship of family member with condition(s) as applicable:
Breast Cancer: ___________________________  Ovarian Cancer: ___________________________
Cervical Cancer: ___________________________  Thyroid disorder: ___________________________
Heart Attack/Angina/Stroke prior to age 50: ___________________________  Uterus removed (hysterectomy): ___________________________

Other Conditions: ____________________________________________________________________________

LIFESTYLE HISTORY:
Alcohol Use?  No  Yes  If yes, average intake (circle applicable):  Daily  Weekly  Amount: _________________
Is your use of alcohol a concern for yourself or others?  No  Yes  If yes, previous treatment/therapy?  No  Yes
Balanced Diet?  Yes  No  If no, how would you rate your diet (circle):  Good  Fair  Poor
Do you consume four (4) servings of dairy/soy products daily or take calcium supplements?  Yes  No
Stable Weight?  Yes  No  If no, are you satisfied with your weight?  Yes  No
Drug use?  Yes  No  If yes, substance: _____________________________________  Frequency (check):  ____ daily  ____ weekly
Have you used needles to inject drugs?  No  Yes
Tobacco Use?  No  Yes  If yes, amount: __________________
Regular Exercise?  Yes  No  If yes, type of exercise: _______________________  Frequency: ______________________
Wear your seatbelt?  Always  Never  Occasionally
History of any type of abuse?  No  Yes  If yes, explain: ________________________  Currently in an abusive situation?  No  Yes
Other History: ____________________________________________________________________________

List medications you are currently taking on a regular basis (include birth control pills): __________________________
_________________________________________________________________________________________

Have you received the HPV Vaccine?  No  Yes  If yes, date: ______________  Are you interested in receiving it?  Yes  No
Have you ever received the TDAP Vaccine?  No  Yes  If yes, date: ______________

Have you had any new medical problems or changes in medications since your last visit?  No  Yes
If yes, explain: __________________________________________________________________________

Please note here anything in particular you want to discuss with the Practitioner: __________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Date of Birth: ______________  Age: _________  Current Telephone Number (include area code): ______________________

PRINT NAME: ______________________________________  STUDENT I.D.# __________________________

Thank you very much!