Today's Date _____

FOR ALL NEW GYNECOLOGICAL PATIENTS

Name _____ Date of Birth _____
Age _____Occupation _____
Are you married? _____
If yes, husband's name and occupation _____
If no, are you currently in a serious relationship? _____

MENSTRUAL HISTORY

Age at first menstrual period _____ Are you still having periods? _____
If no, please skip to ********

If yes, please continue:
How many days between your periods? _____
Do you have regular cycles? _____
If no, have you **ever** had regular cycles? _____
How many days do you bleed? _____
What was the first day of you last menstrual period? _____
When was the period prior to that? _____
Do you feel your periods are light, moderate or heavy? _____
What symptoms do you have during your periods? _____
Do you have problems with serious mood changes prior to your periods?
_____
(You may skip to the next section)

****
What year did you go through your menopause? _____
Have you had any vaginal bleeding since that time?_____
Do you have problems with hot flashes or vaginal dryness? _____
Have you ever been on hormone (estrogen) replacement? _____

GYNECOLOGICAL HISTORY

Please check any of the following that you have **ever** had:
_____Yeast infection _____ Trichomonas _____Genital warts
_____ Herpes _____Chlamydia _____Gonorrhea
_____Syphilis _____Pelvic Inflammatory Disease (PID)

Please check any of the following procedures that you have had:
_____ Endometrial (uterine) biopsy _____LEEP or Cone biopsy

_____ Vulvar, vaginal or cervical biopsy _____Cryosurgery (freezing)
_____ Dilatation & Curettage (D&C) _____Laser surgery
_____ Laparoscopy

Have you ever had any major gynecological surgery? _____
If yes, please list date and type:
_____
_____
When was you last Pap smear? _____
Have you ever had an abnormal Pap? _____
Have you completed the Gardasil (HPV) vaccine? _____
Do you have any problems with pelvic pain or discomfort? _____
Have you ever been told you have endometriosis? _____
Have you ever had vaginal bleeding in between periods? _____
Have you ever had any kidney or bladder problems? _____
_____
Do you ever leak urine when you cough or sneeze? _____
Have you ever had a kidney infection? _____
Have you ever had frequent bladder infections? _____
Have you ever had blood in your urine or passed a kidney stone? _____
Do you know how to preform self-breast exams? _____
Do you do these on a monthly basis? _____
Do you currently have any breast lumps that concern you? _____
Do you have any discharge from you nipples? _____
Have you ever had a mammogram (breast x-ray)? _____
If yes, when was you last one? _____ Was it normal? _____

SEXUAL HISTORY

Are you currently sexually active?_____ If no, please skip this section.
How many different partners have you had in the past two years?_____
Do you have orgasms?_____ Do you have pain with intercourse?_____
Have you or your partner had any recent problems with sexual performance?
_____
If you are still having periods, please complete the following:
What form of contraception are you currently using?_____
Please check all methods that you have **ever** used:
____ Birth control pills ____IUD ____Diaphragm
____ Foam and condoms ____Sponge ____ Rhythm
____ Cervical cap

Are you satisfied with your current form of contraception?_____

OBSTETRICAL HISTORY

Do you have any children? _____ How many? _____

Please list all pregnancies that went beyond 6 months:

Date of delivery	Full term Current or premature	Vaginal or cesarean	Weight	Sex	condition of child
_____	_____	_____	_____	____	_____
_____	_____	_____	_____	____	_____
_____	_____	_____	_____	____	_____
_____	_____	_____	_____	____	_____
_____	_____	_____	_____	____	_____

Did you breast-feed? _____

Please list any complications that you had with any of the pregnancies:
_____
_____

Please list all abortions:

Date	How many weeks pregnant?	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all miscarriages:

Date	How many weeks pregnant?	D&C	Complications?
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Have you ever had a tubal pregnancy? _____ molar pregnancy? _____
Have you ever had difficulty getting pregnant? _____

PAST MEDICAL HEALTH

Please check any of the following that you have had:
____Diabetes ____Hepatitis ____Tuberculosis

____Rheumatic fever	____Heart disease	____High blood pressure
____Blood clots	____Stroke	____Varicose veins
____Asthma	____Thyroid disease	____Emotional problems
____Stomach problems	____Anemia	____Gall bladder disease
____Eating disorders	____Kidney disease	____Alcohol/drug abuse
____Migraines	____Seizures	

Please list any other health problems not mentioned above:
_____
_____
Have you ever been hospitalized for anything other than a pregnancy or operation?_____
Please list all operations that you have had, including dates:
_____
_____
_____

List all medications that you are currently taking:
_____
_____
_____

Please list all medications that you have had an allergic reaction to:
_____
Have you ever had any problems with excessive bleeding or easy bruising?
_____
Have you ever had a blood transfusion?_____
Do you smoke cigarettes? _____ If yes, how many packs per day? _____
How many years have you smoked?_____
If no, have you ever smoked? _____ If yes, when did you quit?_____
Have you ever used recreational drugs, such as marijuana/cocaine, on more that one occasion? _____ Have you ever used IV drugs?_____
How many alcoholic drinks do you have, on average, each week? _____
Have you ever had a problem with drinking to excess? _____
Have you ever had your cholesterol checked? _____ If yes, when? _____
Was it high? _____
Have you ever had a colonoscopy?_____
If yes, when was your last one?_____Did you have any polyps?_____
Have you had a bone density? _____If yes, when?(most recent) _____
Was it normal? _____Osteopenia? _____Osteoporosis? _____

FAMILY MEDICAL HISTORY

Do any diseases run in your family, such as diabetes, high blood pressure, heart disease, high cholesterol, cancer, or osteoporosis?

_____
_____

Please list the current age (or age at time of death) and the medical health of your relatives:

	Alive		Current Age	Current Medical Health
	Yes	No	(or age at time of death)	(or cause of death)
Mother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Sister	☐	☐	_____	_____
Sister	☐	☐	_____	_____
Sister	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Brother	☐	☐	_____	_____
Maternal Grand-Mother	☐	☐	_____	_____
Paternal Grand-Mother	☐	☐	_____	_____

Does anyone in your family have breast cancer? _____
Please list their relation to you and their approximate age at diagnosis:
_____
_____

Does anyone in your family have ovarian cancer? _____
Please list their relation to you and their approximate age at diagnosis:
_____
_____

Does anyone in your family have colon cancer? _____
Please list their relation to you and their approximate age at diagnosis:
_____
_____