

Gynecology Health History

Date: _____



Patient's name _____

Age _____ Race _____ Education _____ Occupation _____ Referring Physician _____

Reason for seeing doctor:

Past Medical History

- | | Patient | Family |
|---|--------------------------|--------------------------|
| 1. Headaches or a nervous disorder..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. A thyroid problem..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A heart condition or high blood pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. A lung disorder..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Breast problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Jaundice, hepatitis, or other liver disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Stomach, bowel or gallbladder problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Kidney or bladder problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Female or sexual problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Allergies or drug sensitivities..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Anemia or blood disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. A blood transfusion..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Birth defects or inherited diseases..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Other medical problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Presently taking medications..... | <input type="checkbox"/> | <input type="checkbox"/> |

Check and detail all findings below. Use reference numbers.

18. Hospitalizations (Check box if more than four)

Mo/yr	Illness or operation	Complications	
		No	Yes
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>
/		<input type="checkbox"/>	<input type="checkbox"/>

19. Obstetrical History Please list the number of: Times pregnant _____

Premature births		Mis-carriages		Abortions		Living children	
No.	Born mo/yr	Weight at birth	Baby's sex	Weeks preg.	Type of delivery	Complications No	Yes
1	/	lb oz				<input type="checkbox"/>	<input type="checkbox"/>
2	/	lb oz				<input type="checkbox"/>	<input type="checkbox"/>
3	/	lb oz				<input type="checkbox"/>	<input type="checkbox"/>
4	/	lb oz				<input type="checkbox"/>	<input type="checkbox"/>
5	/	lb oz				<input type="checkbox"/>	<input type="checkbox"/>

20. Menstrual History

LMP month / day / year Abnormal bleeding
 Onset age Pain
 Cycle days Leukorrhea
 Length days
 Amount per heaviest day pads tampons

22. Family Planning past pres

Oral contraceptive:
 IUD
 Diaphragm
 Other
 Sterilization: Male Female
 Infertility: Yes No
 Duration: _____

21. Sexual History

Sexually active: Yes No
 Frequency: _____ times per _____
 Satisfied:
 Dyspareunia:

23. Marital History

Married Single
 No. of years _____ Sep.
 No. of times _____ Divorced
 Widowed

Signature: _____