GYN MEDICAL HISTORY

All of the information requested below is strictly confidential and will assist your provider in being thorough with your care. If you are uncomfortable with disclosing any of the information asked before you see your provider, feel free to wait until then. Thank you.

Name: _____

Date of Birth: ___/___/_____

Family Health History

Please mark if anyone in your immediate family or your Grandparents have had any of the following:

( ) High blood pressure ( ) Cancer
( ) Heart disease ( ) Blood clot/stroke
( ) Depression/Anxiety ( ) Diabetes
( ) Thyroid problems

( ) Other _____

Your Past Medical History

When was your last pap: _____
Have you ever had an abnormal pap? Yes No
Current method of birth control: _____
Have you ever had any problems with any form of birth Control? Yes No
If yes, please list type of birth control and Problems you had: _____
_____
Age which period first began: _____
First day of last menstrual period: ___/___/___
Is your period regular? Yes No Absent
Cycle length (How often periods come): _____
Pain with period. None Mild Moderate Severe
How long do they last? _____
Severity of flow: Light Mild Moderate Heavy

Please list any surgery and the date it was done:
_____
_____
_____

Are you sexually active?
Currently Previously Never
How many sexual partners have you had in your Lifetime? _____ In the past year? _____

Do you have any history of an STD? Yes No
If yes, please list: _____

Medical conditions you have ever been diagnosed with:

( ) Stroke/blood clot ( ) Migraines
( ) High blood pressure ( ) Cancer
( ) Heart disease ( ) Thyroid problems
( ) Diabetes ( ) Depression/Anxiety

( ) Other _____

Do you wear your seat belt? Yes No
Have you ever had problems with any form of abuse? Yes No
Do you smoke? Yes No
If yes, how many cigarettes/packs per day? _____
Do you use Alcohol? Yes No
Do you use any other drug? Yes No
If yes, what drug was used and when was it last used?
_____
Who currently lives at home with you?
_____
What is your occupation? _____
_____

Number of pregnancies (including miscarriages and abortions): _____
How many (if any) were born preterm? _____
How many miscarriages/abortions have you had? _____
How many children are currently living? _____

Please list the year each child was born, how much he/she weighed, gender, whether it was a c-Section or vaginal delivery, and where each one was born:

Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____
Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____
Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____
Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____
Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____
Year: _____ Wt: _____ Gender: _____
Delivery type: _____ Place: _____

Did you have any problems with any of your pregnancies? Yes No
If yes, please list: _____
_____
_____

Medications being taken regularly:
_____
_____
_____

Medication Allergies:
_____
_____