



INITIAL VISIT GYN HISTORY FORM

Date _____ Name _____

Age _____ Date of Birth _____

Reason for today's visit _____

Allergies _____

Current medications (include OTC's/supplements) _____

Occupation/School _____

YOUR MEDICAL HISTORY

	Yes	No	Staff Comments		Yes	No	Staff Comments
Anemia				High blood pressure			
Asthma/shortness of breath				High cholesterol			
Blood clots				Lung disease			
Breast lump/discharge				Emotional problems/depression			
Breast surgery				Redness or pain in leg			
Cancer				Severe mood changes			
Chest pain				Stroke			
Diabetes				Urinary or kidney infections			
Gallbladder or liver problems				Thyroid problems			
Headaches, frequent				PMS			
Heart problems/murmur				Vision problems			
Infection/problem with uterus, tubes, ovaries				Other Previous Surgeries:			

FAMILY HISTORY

Have your **parents, siblings or grandparents** ever had:
(Please Circle)

Breast Cancer Y N Who:	Colon Cancer Y N Who:
Ovarian Cancer Y N Who:	Uterine Cancer Y N Who:
Other Cancers Y N Who:	High Blood Pressure Y N Who:
Heart Disease Y N Who:	Psychiatric Disorder Y N Who:
Diabetes Y N Who:	Anesthesia Complications Y N Who:
Osteoporosis Y N Who:	Gynecological Disorder Y N Who:

SOCIAL/HEALTH RISK HISTORY

Do you:	Yes	No	Comments
Use tobacco?			Type: _____ How much: How long: _____ months/y
Drink alcohol?			# drinks at a time: #days you have alcohol:
Use recreational/street drugs?			type: _____ frequency:
Use seatbelts?			
Perform monthly self-breast exam?			
Exercise?			type: _____ frequency ___d/w
Have concerns about your weight? History of eating disorder?			
Use tanning beds?			frequency:
Feel threatened or afraid of someone in your life?			
Have a history of sexual assault or abuse?			

INITIAL VISIT GYN HISTORY FORM

Page 2

Have you ever had a pap smear? Yes No

Date of last pap smear _____ results _____

History of abnormal pap smear? Yes No

Abnormal pap smear follow up: _____

What was the **first** day of your last menstrual period? _____

Was your last period normal? Yes No

How often do you get your period? _____ How long does it last? _____

Menstrual flow: light ___ heavy ___

Do you have painful periods? Yes No If yes, how do you manage the pain? _____

Do you miss periods? Yes No

Do you have bleeding between periods? Yes No

Do you have PMS symptoms? If so, describe _____

Do you think you could be pregnant now? Yes No Maybe Total number of pregnancies _____

Living children _____ Abortions _____ Miscarriages _____

Do you currently have?

Unusual vaginal discharge: No Yes color _____ odor _____

Vaginal or genital: itching ___ sores ___ bumps ___ rash ___ none ___

Pain or bleeding with intercourse Yes No

Pain or pressure in abdomen or back Yes No

Sexual/Contraceptive History

Age at first sexual intercourse _____

Have you ever had sexual contact? Yes No If yes, vaginal ___ anal ___ oral ___

If yes, with: men women ___ both ___ Have you been sexually active this past year? Yes No

Length of time with current or most recent partner: _____

> 1 partner this past year? Yes No Number of lifetime partners: _____

Are you using condoms to prevent pregnancy or infection?

Always Sometimes Never

Have you ever been tested for STD's Yes No

Have you or your partner ever had: Chlamydia Genital warts (HPV) Herpes Gonorrhea Hepatitis B

Do you want to be tested for sexually transmitted diseases today? Yes No

Birth control

What birth control methods are you currently using? (Include condoms, spermicides, etc.) _____

Are you having any problems with this method? _____

Birth control method requested today _____