

GYNECOLOGY HEALTH HISTORY FORM

Preferred Name if different from above: _____

Date: _____

Gender: Male Female Other: _____

Single Married Divorced Partnered (with: same sex opposite sex other: _____)

Undergraduate Graduate Major: _____ Graduation Date: _____

Reason for visit: Annual Exam Pap smear Discuss contraception Refill contraceptives STI testing Other _____

Past History:

Surgeries (type of surgery and dates): _____

Chronic medical conditions: _____

Hospitalizations: _____

Migraine headaches Yes No Liver disease Yes No Blood Clots Yes No

Gynecological History:

Date of last Pap smear: _____ Date of last yearly exam (if different): _____

Have you ever had an abnormal pap? (date): _____ Have you had a colposcopy/LEEP? (date): _____

First day of last 2 menstrual periods: _____ & _____ How long does period last? _____

Usual number of days from start of one period to start of next: _____ Irregular bleeding or spotting? Yes No

Are you/have you ever been sexually active: Never been Not currently Yes I am active - for <3 yrs for >3 yrs

Do you have sex with men, women both or other _____

Have you had more than 5 lifetime sexual partners? Yes No

Have you had a change in partners in the past 3 months? Yes No

Current method of contraception/STI prevention: Nothing Condoms Patch Nuvaring Depo IUD Pill (name): _____

Total number of pregnancies if any: None; # of children: _____; # of miscarriages: _____; # of terminations: _____

Social History:

Do you use/take/do the following? If yes how much and how often?

Tobacco: No Yes _____ Caffeine: No Yes _____

Alcohol: No Yes _____ Multiple vitamin: No Yes _____

Recreational Drugs: No Yes _____ Exercise: No Yes _____

Calcium (supplements): No Yes _____

Do you wear bike helmets/seatbelts? Yes No Do you frequently feel depressed or anxious? Yes No

Do you feel safe in your living environment? Yes No Have you ever had a mammogram? Yes No

Are you happy with your weight? Yes No Have you ever had your cholesterol checked? Yes No

Immunizations:

Have you received all 3 Gardasil (HPV) vaccinations? Yes No Chickenpox? (circle) had disease/vaccination? Yes No

Biological Family History: Please check YES or NO. If YES, please circle the choice(s) in the line that corresponds with your YES response.

Diabetes Yes No Stroke/cardiovascular disease/High cholesterol Yes No

Breast/Ovarian/Uterine cancer Yes No Lung/Skin/Colon cancer Yes No

Blood Clots/Bleeding Disorder Yes No

Other pertinent history: _____
