

Gynecology History & Physical: Patient History

Name _____ Date _____ DOB _____

Gynecologic History

Periods are: Regular Interval between periods? _____ days Period lasts: _____ days

Irregular (please explain) _____

I have not had a period since _____

Do you have pain/cramps with your periods? No Minor Moderate Severe

Have you ever had? Herpes Chlamydia Gonorrhea Genital Warts Trichomonas Syphilis

Have you ever had an abnormal pap smear? No Yes, when? _____

How many times have you been pregnant?

Vaginal Deliveries _____ C-Sections _____ Miscarriages _____ Abortions _____

Past Medical History and Family History

Please check if you or a family member have any of the following conditions

	You	Family	Explanation
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (breast/female organs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (other)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures/Nerve/Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis/Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone/Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Throat/Sinus Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Disease/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Free Bleeding/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phlebitis/Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rape/Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any surgery you have had: _____

Social History

Do you smoke? Yes _____ Packs per Day Never Quit _____

How much alcohol do you drink per week? _____ Do you use any street drugs? _____

Are you single married divorced separated widowed

Occupation _____