ADULT GYN HISTORY

Date: _______________

Name: ___________________________________ Age: _______ DOB: ___________________

Reason for visit: ____

____

Date of last gyn/ pap exam: _____________ Date of last mammogram: ____________

Have you ever had an abnormal mammogram or pap? ❑ Yes ❑ No

Treatment: ____

Menstrual History:

Date of last period: ____________

Period length: ________ days

Cycle length: ________ days

Period Flow: ❑ Light ❑ Medium ❑ Heavy

Concerns with PMS? ❑ Yes ❑ No

Sexual History:

Sex of partner: ❑ Male ❑ Female ❑ None

Number of partners in past six months: ______

Pain with intercourse? ❑ Yes ❑ No

Bleeding with intercourse? ❑ Yes ❑ No

Bleeding between periods? ❑ Yes ❑ No

Pregnancy/ Contraception:

Number of Pregnancies: _______

Miscarriages: ______

Abortions: ________

Pregnancy complications? ❑ Yes ❑ No

Concerns about fertility? ❑ Yes ❑ No

Current plans for pregnancy: ____

Current form of contraception: ❑ None ❑ Pill ❑ Surgical ❑ Natural ❑ Condom ❑ IUD ❑ Diaphram ❑ Other: ______________________________

Happy with current form of contraception? ❑ Yes ❑ No

Concerns about menopause? ❑ Yes ❑ No

Difficulty with: ❑ hot flashes ❑ vaginal dryness ❑ emotional changes ❑ leaking urine ❑ breast pain

Medical History:

Have you or your partner ever had:

	Myself Yes	*Myself* No	*Partner* Yes	*Partner* No
Gonorrhea	❑	❑	❑	❑
Chlamydia	❑	❑	❑	❑
Syphilis	❑	❑	❑	❑
Herpes	❑	❑	❑	❑
PID (pelvic infection)	❑	❑	❑	❑
Hepatitis (liver infection)	❑	❑	❑	❑
Genital warts	❑	❑	❑	❑
Exposure to HIV	❑	❑	❑	❑

Have you or a relative ever had:

	Yes	No	Who?
High Blood Pressure	❑	❑	_________
Heart attack	❑	❑	_________
Blood clots	❑	❑	_________
Alcoholism/depression	❑	❑	_________
Birth defects	❑	❑	_________
Mental retardation	❑	❑	_________
Cystic fibrosis	❑	❑	_________
Breast/ovary/ uterine cancer	❑	❑	_________
Colon cancer	❑	❑	_________
Skin cancer	❑	❑	_________
Migraine headaches	❑	❑	_________
Seizures	❑	❑	_________
Muscular dystrophy	❑	❑	_________
Hemophilia	❑	❑	_________

Do you perform self breast exams? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If yes, how much? ____________________

Do you drink more than (7) alcoholic drinks per week? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No Type and frequency: ___________________

Do you diet? ❑ Yes ❑ No Type: ______________________________

What medication and vitamins do you take? ____

____

Have you had any new medical surgical problems since your last check up? ______________________