



Patient's name: _____ Date: _____
 Date of birth: _____ age: _____ primary language _____
 Reason for today's visit: _____

For the items below. Circle Y or N unless specific information is requested

GYN HISTORY

Age at first menstrual period _____
 Periods regular? Y N
 Periods irregular? Y N
 Every _____ days
 Number of days of flow _____
 First day of last menses _____
 Abnormal pap smear Y N
 Breast problems Y N

OBSTETRIC HISTORY

Infertility Y N
 Number of times pregnant _____
 Number of live births _____
 Number of vaginal deliveries _____
 Number of c-sections _____
 Number of miscarriages _____
 Number of abortions _____
 Number of ectopics _____
 Number of multiples _____
 Obstetric complications _____

Sexually active now? Y N
 Birth control method used _____

PAST SURGICAL HISTORY

YEAR

Appendectomy	Y	N	_____
Tonsillectomy	Y	N	_____
Tubal ligation	Y	N	_____
Gallbladder	Y	N	_____
Breast mass/cyst	Y	N	_____
Hysterectomy	Y	N	_____
Ovaries	Y	N	_____
Anesthetic complications	Y	N	_____
Other operations	Y	N	_____

Allergies Y N
 (if yes, please list): _____

PAST MEDICAL HISTORY

YEAR

Heart disease	Y	N	_____
Hypertension	Y	N	_____
Diabetes	Y	N	_____
Pneumonia/asthma	Y	N	_____
Bronchitis	Y	N	_____
Thyroid problems	Y	N	_____
Kidney problems	Y	N	_____
Liver problems	Y	N	_____
Bowel problems	Y	N	_____
Autoimmune disorder	Y	N	_____
Neurological/epilepsy	Y	N	_____
Psychiatric	Y	N	_____
Orthopedic problems	Y	N	_____
Varicosities/phlebitis	Y	N	_____
Arthritis	Y	N	_____
Skin problems	Y	N	_____
Trauma/domestic violence	Y	N	_____
Gonorrhea	Y	N	_____
Syphilis	Y	N	_____
Chlamydia	Y	N	_____
Herpes	Y	N	_____
Human papilloma virus	Y	N	_____
Vaginal warts	Y	N	_____
Trichomonas	Y	N	_____
Bacterial Vaginosis	Y	N	_____
Yeast	Y	N	_____
ADIS/HIV	Y	N	_____
Uterine Anomaly/DES	Y	N	_____
Other Problems:			_____

Family history of cancer	Y	N
Family history of heart disease	Y	N
Family history of hypertension	Y	N
Family history of diabetes	Y	N
Have you had a transfusion?	Y	N
Do you smoke?	Y	N
Do you drink daily?	Y	N
Use recreational drugs?	Y	N
What is your occupation?		_____

History reviewed by: _____

Comments: _____