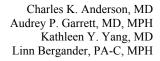


MEDICAL HISTORY FOR GYNECOLOGICAL CARE

				,		
Date				Main reas	son for visit:	
						_
Print Last Name	First Name	Middle	Name			
Age	Date Of Birth	Occupa	tion			
		· · · · · · · · · · · · · · · · · · ·				
Address	City	State	Zip	Years of S	SC11001	
Partner's Name Who is your Primary Ca				Age	Occupation	
Who is your Primary Ca	re Physician?					
Medical History: Have				olems with th		
Anemia	Asthma/Bronchi		Blood Clots		Blood Disorders	High Cholesterol
Diabetes	Eating disorders		Epilepsy/fair	nting	Emphysema	Gall Bladder Disease
Gonorrhea	Headaches		Heart Diseas		Hemorrhoids	Hepatitis
Herpes		Problems	ems High Blood Pressure		Kidney Disease	Liver Disease
	Mental Health P				Pelvic Infections	Pneumonia
Lung Disease		robiems				
Rheumatic Fever	Stomach Ulcers		Stroke		Thyroid Problems	Uterine Growth
Circle any symptoms y						
Fever/chills	Nausea/vomiting	3	Joint pain/sti		Blood in Urine	
Unusual Fatigue	Diarrhea/constipation Join		Joint swellin	g	Urinary frequency/pres	ssure /Incontinence
Weight change>10lbs.			Breast lump/	discharge	Vaginal discharge/ spo	otting
Poor Appetite			Skin rash/itcl		Bleeding after intercou	
Chest Pain				6	Pain with urination	Pain with intercourse
	Getting full more quickly Anx					i am with intercourse
Shortness of Breath			Depression		Bruise easily	
Chronic Cough			Panic attacks		Swollen Glands	
Coughing up blood			Unexplained	bleeding		
Other:						
Surgical History: List o	perations you have	had and	the reason for	surgery. Plea	ase give approximate ye	ar and list in chronological
order, if possible, includ	ing tonsils, D&C, C	C-Section	s, etc.			
<u>#1</u>						
<u>#2</u>						
<u>#3</u>						
# <u>3</u> # <u>4</u>						
#5						
# <u>6</u>						
Have you had a blood tra	onefucion?					
-) II			9	
History of any serious	<u>medical problems :</u>	! Have yo	ou ever been i	<u>nospitalized</u>	<u>''</u>	
Medications: Please lis	t any medicines (pr	escription	ns or over-the-	counter) you	ı take:	
Medicine Amou	•	ften takeı		<u>Medici</u>		How often taken





Allergies: Please list medication and what reaction you had:

Family History: Has any member	of your family, inclu	uding parents, gran	dparents, brothers, or	sisters ever had: (list person or		
persons involved):						
	d were they when the		did th	is person die of the disease		
Breast Cancer:						
Ovarian Cancer:						
<u>Uterine Cancer:</u>						
Other Cancer:						
Diabetes		Heart disea	ise			
High blood pressure		Kidney dis	ease			
Lung disease		Blood clots	3			
Lung disease Excessive bleeding (with dental ex	tractions, child birth	etc.)				
Breasts:						
Have you ever had a mammogram	?	Date of las	t mammogram			
Have you had a breast biopsy?						
Colon:						
Have you ever had a colonoscopy?	Date	of last colonoscopy /	result			
Bone Density:						
Have you had bone density screening?	Date:					
Menstrual History:						
What was the first day of your last	normal menstrual pe	eriod?				
At what age did your menstrual per	riods begin?	How long are	your usual menstrual	cycles? (28-30 days apart?)		
What is an average number of days Date of your last PAP smear?	3 you flow?	Any Cram	ps?	Is the flow heavy?		
Date of your last PAP smear?	Have yoι	ı ever hand an abno	ormal PAP smear?	When?		
If yes, please explain: Age of Menopause, if applicable _		Symj	otoms?			
Birth Control History (if applica						
Present method Problems with present or prior met			last Used?			
Problems with present or prior met	hods					
Pregnancy History:						
Number of: Pregnancies Li	ive hirths I	iving Children	Miscarriages	Therapeutic Abortions		
How old is your youngest child?	Rirth weight	·· I argest	Miscarrages Smallest	Age at first pregnancy		
What problems did you have with p	nrior pregnancies hi	irths or abortions?	Smanest			
what problems and you have with p	prior pregnancies, or	itins of adortions:				
Social History: Do you smoke?		How much?				
How much alcohol do you drink?		110 W III.				
What drugs have you used (marijua	ana amnhetamines	cocaine?)				
Have you ever shared needles?	ana, ampiretamines,					
Have you ever shared needles? On a scale of 1 – 10 (1=very poor;	10 =excellent) how	would you rate: yo	ur ioh / work situation	n? Home?		
If applicable, how would you rate y	your relationship wit	th vour snouse / nat	ur joo / work situutior tner?	1:110Hic:		
Have you ever had problems with y	your sex life?	in your spouse / par				
Have you ever heen hurt by sex?	your sex me:					
Have you ever been hurt by sex?	a sevual encounter?)				
Trave you ever been forced to have	a sexual encounter:					
What is your height?	Recent	Recent weight?		Desired weight?		
Are there any special concerns you wo	uld like to discuss with	h the doctor during yo	our visit?			