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WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER

MEDICAL HISTORY FOR GYNECOLOGICAL CARE

Date_____

Print Last Name First Name Middle Name

Age Date Of Birth Occupation

Address City State Zip

Main reason for visit:

Years of School_____

Partner's Name_____ Age_____ Occupation _____
Who is your Primary Care Physician? _____

Medical History: Have you ever had or do you have now any problems with the following: Please Circle

Anemia	Asthma/Bronchitis	Blood Clots	Blood Disorders	High Cholesterol
Diabetes	Eating disorders	Epilepsy/fainting	Emphysema	Gall Bladder Disease
Gonorrhea	Headaches	Heart Disease	Hemorrhoids	Hepatitis
Herpes	Hearing/Vision Problems	High Blood Pressure	Kidney Disease	Liver Disease
Lung Disease	Mental Health Problems	Ovarian Cyst or tumor	Pelvic Infections	Pneumonia
Rheumatic Fever	Stomach Ulcers	Stroke	Thyroid Problems	Uterine Growth
				Colon Cancer

Circle any symptoms you have currently:

Fever/chills	Nausea/vomiting	Joint pain/stiffness	Blood in Urine	
Unusual Fatigue	Diarrhea/constipation	Joint swelling	Urinary frequency/pressure /Incontinence	
Weight change>10lbs.	Bloating	Breast lump/discharge	Vaginal discharge/ spotting	
Poor Appetite	Rectal Bleeding	Skin rash/itching	Bleeding after intercourse	
Chest Pain	Getting full more quickly	Anxiety	Pain with urination	Pain with intercourse
Shortness of Breath	Heartburn	Depression	Bruise easily	
Chronic Cough	Change in bowel habits	Panic attacks	Swollen Glands	
Coughing up blood	Abdominal pain	Unexplained bleeding		

Other:_____

Surgical History: List operations you have had and the reason for surgery. Please give approximate year and list in chronological order, if possible, including tonsils, D&C, C-Sections, etc.

#1_____
#2_____
#3_____
#4_____
#5_____
#6_____

Have you had a blood transfusion? _____

History of any serious medical problems? Have you ever been hospitalized?

Medications: Please list any medicines (prescriptions or over-the-counter) you take:

Medicine	**Amount**	**How often taken**	**Medicine**	**Amount**	**How often taken**

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Allergies: Please list medication and what reaction you had:

_____

_____

_____

Family History: Has any member of your family, including parents, grandparents, brothers, or sisters ever had: (list person or persons involved):

Cancer: Person How old were they when they had the disease did this person die of the disease

Breast Cancer: _____

Ovarian Cancer: _____

Uterine Cancer: _____

Other Cancer: _____

Diabetes _____ Heart disease _____

High blood pressure _____ Kidney disease _____

Lung disease _____ Blood clots _____

Excessive bleeding (with dental extractions, child birth etc.) _____

Breasts:

Have you ever had a mammogram? _____ Date of last 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 period? _____

At what age did your menstrual periods begin? _____ How long are your usual menstrual cycles? (28-30 days apart?) _____

What is an average number of days you flow? _____ Any Cramps? _____ Is the flow heavy? _____

Date of your last PAP smear? _____ Have you ever had an abnormal PAP smear? _____ When?_____

If yes, please explain: _____

Age of Menopause, if applicable _____ Symptoms? _____

Birth Control History (if applicable):

Present method _____ last Used? _____

Problems with present or prior methods _____

Pregnancy History:

Number of: Pregnancies _____ Live births _____ Living Children _____ Miscarriages _____ Therapeutic Abortions _____

How old is your youngest child? _____ Birth weight: Largest _____ Smallest _____ Age at first pregnancy _____

What problems did you have with prior pregnancies, births or abortions? _____

Social History: Do you smoke? _____ How much? _____

How much alcohol do you drink? _____

What drugs have you used (marijuana, amphetamines, cocaine?) _____

Have you ever shared needles? _____

On a scale of 1 – 10 (1=very poor; 10 =excellent) how would you rate: your job / work situation? _____ Home? _____

If applicable, how would you rate your relationship with your spouse / partner? _____

Have you ever had problems with your sex life? _____

Have you ever been hurt by sex? _____

Have you ever been forced to have a sexual encounter? _____

What is your height? _____ Recent weight? _____ Desired weight? _____

Are there any special concerns you would like to discuss with the doctor during your visit?

_____

_____

_____

_____

Thank You! The Medical History Form will go directly to your physician.