



Charles K. Anderson, MD  
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## 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       |

**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!!!