

GYNECOLOGIC HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Chief reason for today's visit: _____

Date of last period (first day): _____

Date of last pap smear: _____ Results: _____

Type of birth control currently using: _____
(Including vasectomy, tubal, or abstinence)

Are you happy with it? _____

OBSTETRICAL HISTORY

Are you currently pregnant? _____ Pregnancy test: _____

Total number of times pregnant (include abortions, miscarriages): _____

total number of live births _____

total number of miscarriages _____

total number of therapeutic abortions _____

Any complications during your pregnancies? _____ (If yes, please explain)

Did you have a Caesarean Section? _____

What was the weight of your largest baby? _____

Any family history of inherited disorders (i.e. Tay Sachs, neural tube defects, Downs Syndrome, mental retardation)?

GYNECOLOGICAL HISTORY

Age at first period _____ How long do your periods last? _____

How often do your periods come? 28-30 days _____ Less _____ More _____

How heavy is your menstrual flow? _____

Do you have bad cramps? _____ PMS symptoms? _____

Any bleeding between periods? _____ Any bleeding after sex? _____

Any problems with urination (loss of urine while coughing, sneezing, etc.)? _____

Check any of the following problems that you have had either in the past or currently:

- | | |
|-------------------------------------|---|
| _____ Gonorrhea | _____ Surgery on female organs |
| _____ Infection in tubes of ovaries | _____ Abnormal pap smears |
| _____ Herpes | _____ IUD related problems |
| _____ Vaginal infections | _____ History of physical or sexual abuse |

MEDICAL HISTORY

How is your health in general? _____

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

Are you a past smoker? _____ When did you quit? _____

Do you drink alcohol? _____ How much? _____

Do you have (or have you had) any medical or psychiatric illness? (If yes, please explain)

Have you ever been hospitalized for a medical illness? (If yes, please explain)

What operations have you had? (including tonsillectomy, D&C, knee surgery, etc.)

Do you have any allergies to medications? _____	Do you have any other allergies? _____
Please list: _____	Please list: _____
_____	_____
_____	_____

Do you have any history of a bleeding disorder? _____ Had a blood transfusion? _____
Do you use any medication on a regular basis? _____ (If yes, please explain)

Have you had a mammogram? _____ Date of last mammogram _____
Do you have any problems with your breasts? (lumps, discharge or pain) _____

FAMILY HISTORY

SOCIAL HISTORY

Breast cancer _____

Heart disease _____

Marital status _____

Uterine cancer _____

High blood pressure _____

Diabetes _____

Stroke _____

Colon or rectal cancer _____

Osteoporosis _____

Thyroid disease _____