Gynecology Care Specialists

women caring for women

Medical History Update

Name_____ Date of Birth_____Age _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Reason for Visit: Annual Problem_____

Allergies: _____

Latex: Yes____ No____ Iodine: Yes____ No____

Menstrual History

First Day of Last Period_____ Regular Cycle: Yes_____ No_____ Cycle Frequency *(start to start)*_____
Length_____ Flow: Light_____ Moderate_____ Heavy_____ Post Menopausal: Yes_____ No_____

Obstetrical History

Pregnancy since last visit? Yes ____ No ____ Outcome: Delivery _____ Abortion _____ Miscarriage _____

Medical Information

Current Birth Control_____ Last Pap Smear_____
Last Mammogram_____ Last DEXA Scan_____ Last Colonoscopy/Cologuard_____

Medical History

Medical Problems / Surgeries since last visit? _____

_____

Medication List *(Include dosage)*

_____ _____
_____ _____
_____ _____

Social History

Smoking: Yes____ No____ Never____ Formerly____ Cigarettes per day?_____
Drinking: Yes____ No____ How much per day?_____
Illegal Drugs: Yes____ No____ Never____ Formerly_____ Currently_____
Exercise: Yes____ No____
Sexually Active: Yes____ No____ How Many Sexual Partners: Lifetime_____ Last Year_____
Current/Past History of Physical, Sexual, Emotional Abuse: Yes____ No____
Are you safe at this time?_____

Preferred Pharmacy _____

Changes in Family Medical History:

_____

_____

Patient Signature_____ **Date**_____