Gynecology Care Specialists

women caring for women

History

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______________ Age at First Period__________ Regular Cycle: Yes____No____ Cycle Frequency (start to start) ______________

Length_____________ Flow: Light______ Moderate_________ Heavy_________ Post Menopausal: Yes_____ No____Year of Last Period_______________

Obstetrical History

Total Pregnancies_________ Total Living__________ Miscarriages__________ Abortions________ Vaginal Deliveries__________ C-Section Deliveries________

Medical Information

Current Birth Control____________________________ Last Pap Smear_____________ History of abnormal Pap Smear? Yes _________ No ___________

History of: Colposcopy ____________ LEEP _________________ Cryo ____________ When? ____

Last Mammogram________________ Last DEXA Scan____________ Last Colonoscopy/Cologuard____________

Medical History ***(Please check if you had or now have any of the following)***

Anemia______ Bleeding Disorder_____ Blood Clot in leg/lung______ Breast Problems____

Cancer______ Colitis/Crohns______ Depression/Anxiety______ Diabetes______

Endometriosis______ Gastric Reflux/IBS____ Fibroids______ Heart Disease______

Heart Murmur/MVP______ Hemorrhoids______ Hepatitis______ High Cholesterol____

HIV/AIDS______ Infertility______ Kidney Problems______ Seizures______

Migraine Headaches______ Osteoporosis______ Stomach Ulcer______ Stroke______

High Blood Pressure ______ Thyroid Disease_____ Asthma/Lung Problems ______ PCOS ______

Other ____

____

____

Surgical History

1. ____ Year_______________
2. ____ Year_______________
3. ____ Year_______________
4. ____ Year_______________
5. ____ Year_______________

Medication List *(Include dosage)*

1. ____ 6. ____
2. ____ 7. ____
3. ____ 8. ____
4. ____ 9. ____
5. ____ 10. ____

Social History

Smoking: Yes____ No____ Never____ Formerly____ Quit When__________ Currently_________ 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 ____

Family History *(Please circle all that apply)* **Who in the family was affected?**

Anemia Asthma Blood Clot in leg/lung High Cholesterol Diabetes

Thyroid Disease Epilepsy High Blood Pressure Stroke Migraine Headache

Cancer: Colon Ovarian Pancreatic Cervical Uterine Breast

Patient Signature____ **Date**____________________