PATIENT SELF HISTORY

GYNECOLOGIC HISTORY

Last Name:	First Name:
Today's Date:	Birth Date: / / Age:
Preferred phone number for our office to call you for lab result follow-up: ( )	
Marital Status: Married Living with partner Single Widowed Divorced	
Sexual Orientation: Heterosexual Homosexual Bisexual	
Number of living children:	Number of people in household:
School completed: High School Some College College Graduate degree Other	
Occupation:	Employer:

ANCESTRY & CLINICAL HISTORY

CAUCASIAN	MEDITERRIAN	BLACK	FRENCH CANADIAN
ASHKENAZI JEWISH	HISPANIC	ASIA	OTHER:

GYNECOLOGIC HISTORY

If you are uncomfortable answering any of the following questions, leave them blank. You may discuss them with your docto

	Yes	No		Yes	No
First day of your last period:			Have you ever had an ovarian cyst?		
Age periods began:			Are you currently sexually active?		
Are your periods regular?			Have you ever had sex?		
Length of periods (total number of days of bleeding):			Length of time with current partner?		
Number of days between periods:			Number of sexual partners (lifetime):		
Any recent changes in your periods?			Present method of birth control:		
Do you have heavy vaginal bleeding or clots?			Have you ever used birth control pills?		
Do you have very painful periods?			Have you ever used an IUD?		
Do you experience premenstrual symptoms?			Are you interested in a new form of		
Do you experience hot flashes?			birth control?		
Have you gone through menopause?			Have you ever had a sexually transmitted		
Have you had any postmenopausal bleeding?			infection?		
Have you ever taken hormone replacement			Which one?		
therapy or alternative therapies?			Do you lose urine when coughing of lifting?		
When was your last Pap smear?			Do you experience a strong urgency to urinate?		
Do you have a history of fibroids?			Do you ever incompletely empty your		
Have you ever had an abnormal Pap smear?			bladder?		
Have you ever had a procedure called a			Do you have any unintended urine loss?		
colposcopy, cryosurgery, or cone biopsy?			Do you have pain with urination?		
When was your last mammogram?			Have you ever had blood in your urine?		
What was the result?			Do you urinate frequently?		
Do you do regular breast self-examinations?			Do you urinate more than one time over night?		

OBSTETRIC HISTORY

	Number		Number		Number
Total pregnancies		Abortions		Miscarriages	
Live births		Premature births		Living Children	

#	Birth Date	Birth Wt.	Male/Female	Weeks Preg	Type of delivery(vaginal/cesarean sec,etc)	Complications
1						
2						
3						
4						

Please turn over and fill out the other side

	PERSONAL PAST HISTORY OF ILLNESSES				
Major Illnesses	**Yes (when)**	**No**	**Major Illnesses**	**Yes (when)**	**No**
High blood pressure	❒	❒	Depression/ anxiety	❒	❒
Diabetes	❒	❒	Collagen vascular disease (lupus)	❒	❒
Heart attack/ heart problems	❒	❒	Rheumatic fever	❒	❒
Asthma	❒	❒	Reflux/ hiatal hernia/ ulcer	❒	❒
Pneumonia/ lung disease	❒	❒	Bowel problems	❒	❒
Blood clots in lungs or legs	❒	❒	Gallbladder disease	❒	❒
Stroke	❒	❒	Hepatitis/ jaundice/ liver disease	❒	❒
Kidney infections/ stones	❒	❒	Glaucoma/ cataracts	❒	❒
Thyroid disease	❒	❒	Tuberculosis	❒	❒
Anemia	❒	❒	HIV/ AIDS	❒	❒
Blood transfusions	❒	❒	Cancer	❒	❒
Arthritis/ joint pain/ back problems	❒	❒	Chicken pox	❒	❒
Seizures/ convulsions/ epilepsy	❒	❒	Other	❒	❒

OPERATIONS AND HOSPITALIZATIONS

Reason	Date	Hospital

CURRENT MEDICATIONS and DRUG ALLERGIES

Including hormones, vitamins, herbs, nonprescription medications

Drug Name	Dosage	Who prescribed	Drug Name	Dosage	Who prescribed

Do you have any known allergies to any medications? Yes ❒ No ❒ If yes, please list below

Drug Name	Allergic reaction	Drug name	Allergic reaction

SOCIAL HISTORY

Do you or have your ever smoked cigarettes?			Yes ❒	No ❒
Packs per day:	Years:	Quit:		
Alcohol: Drinks per day:	Drinks per week:		Yes ❒	No ❒
Recreational drug use:			Yes ❒	No ❒
Regular exercise:	How long and how often?		Yes ❒	No ❒
Have you ever been sexually abused, threatened, or hurt by anyone?			Yes ❒	No ❒

FAMILY HISTORY

Mother: living deceased-cause:				Father: living deceased-cause:			
Siblings: number living: number deceased:				Children: number living: number deceased:			
ILLNESS	**No**	**Yes**	**WHICH RELATIVE (S)**	**ILLNESS**	**No**	**Yes**	**WHICH RELATIVE (S)**
Diabetes	[ ]	[ ]		Asthma	[ ]	[ ]	
Stroke	[ ]	[ ]		Mental illness	[ ]	[ ]	
Heart disease	[ ]	[ ]		Colon cancer	[ ]	[ ]	
Blood clots	[ ]	[ ]		Ovarian cancer	[ ]	[ ]	
High blood pressure	[ ]	[ ]		Uterine cancer	[ ]	[ ]	
High cholesterol	[ ]	[ ]		Breast cancer	[ ]	[ ]	
Osteoporosis	[ ]	[ ]		Other cancer	[ ]	[ ]	

Signature of patient: Signature of practitioner: