



Women's Health Specialists

Name:	Reason for Visit:	Date of Visit:
Date of Last Pap Smear:	Date of Last Mammogram:	Date of Birth:
Primary MD:	Occupation:	Age:

GYNECOLOGIC HISTORY:

Date of last menstrual period: _____ Unsure Menopausal – if so, age of menopause: _____

Age of first period: _____ Number of days between periods: _____ Days of flow/bleeding: _____

Flow (circle those applicable): Light Medium Heavy Clots Bleeding between periods

Current method of birth control: _____

Have you **ever** had any of the following:

	Yes	No	Date		Yes	No	Date
Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>		Heavy or Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>		Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroids of the Uterus	<input type="checkbox"/>	<input type="checkbox"/>		Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence of Urine	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>		Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>	

Comments/Treatment:

PREGNANCY HISTORY:

Times Pregnant _____ Term Births _____ Premature Births _____ Miscarriages _____ Abortions _____ Living Children _____

No.	Date (mm/dd/yy)	Wks Gest	Labor (hours)	Baby's Weight	Gender	Delivery Type (Vag or C/S)	Pain Meds	Complications
1								
2								
3								
4								
5								

Comments:

MEDICATIONS (ALL – including over-the-counter medications or herbal supplements; if needed, attach separate list)

MEDICATION	DOSAGE	INDICATION

[TURN OVER]

ALLERGIES

MEDICATION	REACTION

No known drug allergies

MEDICAL HISTORY - Have you ever had any of the following:

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots (also known as DVT or PE)	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>
Breast Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal reflux (severe heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Treatment:					

SURGICAL HISTORY

DATE	OPERATION	INDICATION	COMPLICATIONS

FAMILY HISTORY – Does anyone in your family have:

	Yes	No	Family Member		Yes	No	Family Member
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Other (please explain below)	<input type="checkbox"/>	<input type="checkbox"/>	
Comments:							

SOCIAL HISTORY

Marital Status: Married Single Domestic partner Divorced Widowed

Number of sexual partners in the last two years – Male: _____ Female: _____

Do you smoke or use tobacco products? Current Past Never

If current, how much do you smoke per day: _____ If past, how many years ago did you quit: _____

Do you exercise regularly? Yes No If Yes, how often and what type: _____

Do you drink alcohol? Yes No If Yes, how much and how often: _____

Do you use any illicit drugs? Yes No If Yes, what type and how often: _____

Patient's Signature: _____

Doctor's Signature: _____