GYNECOLOGY HISTORY RECORD AND PATIENT QUESTIONNAIRE

New Life CLINIC

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Is your visit today for: ☐ Your annual ☐ Pregnancy ☐ A problem

If being seen for a problem, please list reason: _____

PAST MEDICAL HISTORY

MEDICATIONS

Are you taking medication(s) regularly? YES NO

If yes, please list the name(s), dosages, and prescriber:

_____

_____

_____

_____

ALLERGIES

Are you have an allergy to latex? YES NO

Are you allergic to any medications?

If yes, please list the name(s) below and the reaction:

_____

_____

_____

FAMILY HISTORY:

Have any of your ***blood relatives*** had any of the following conditions? Circle "Yes" or "No" and list relation and their age.

Breast Cancer:	YES NO	_____
Ovarian Cancer:	YES NO	_____
Colon Cancer:	YES NO	_____
Uterine Cancer:	YES NO	_____
Diabetes	YES NO	_____

SOCIAL HISTORY:

Do you use drugs? YES NO

Do you smoke? YES NO

If yes, how many per day? _____

Do you Drink Alcohol? YES NO

If yes, how many drinks per day/week? _____

Do you exercise regularly? YES NO

HOSPITAL/SURGICAL HISTORY:

_____

_____

_____

PRIMARY CARE PHYSICIAN

_____

PREGNANCY HISTORY: (Enter total number in each)

Pregnancies: _____ Abortions: _____

Live Births: _____ Stillborn: _____

Miscarriages: _____ Living: _____

Age at time of first child: _____

PAP SMEAR HISTORY:

Last PAP smear date: _____

Results: ☐ Normal ☐ Abnormal

Abnormal PAPS in the Past? YES NO

If yes, list date(s), tests/treatments:

_____

MAMMOGRAMS

Date of last Mammogram: _____

Location: _____

Because abuse and violence are so common in women's lives, we have begun to ask routinely, are you in a relationship in which you have been physically hurt or threated by your partner? YES NO

Patient Name: _____ Date of Birth: _____

Have you had any of the following conditions?

Cancer YES NO

If yes what kind? Diagnosis Date: _____

Diabetes YES NO

Gallbladder/Gastrointestinal/Liver YES NO

Heart Problems/High Blood Pressure YES NO

Thrombophlebits/Blood Clots YES NO

High Cholesterol YES NO

Last Cholesterol Check Date _____ Result if Known _____

Sickle Cell Anemia/ Blood Disorders YES NO

Blood Transfusion YES NO

Thyroid Disease YES NO

Migraine/Vascular Headaches YES NO

Rheumatic Fever as a child YES NO

Infection of Fallopian Tubes YES NO

Recurrent Urinary Tract Infections YES NO

Kidney Problems YES NO

Asthma/TB YES NO

Hepatits YES NO

Sexually Tramismitted Disease YES NO

If yes, circle which ones: Herpes Genital Warts Gonoorrhea Chlamydia Syphillis

Psychiatric Diagnosis YES NO

If so Which Diagnosis: _____

Serious Injuries YES NO

Loss of urine while coughing YES NO

Urinary Urgency YES NO

Constipation YES NO

Mitral Valve Proplapse YES NO

Any heart condition requiring anitbiotics before surgery or dental procedure YES NO

MENSTRUAL HISTORY:

At what age did you periods begin? _____

Interval between periods (first day to first day): _____

How long do your periods last? _____

Amount of flow: ☐ Light ☐ Moderate ☐ Heavy

Cramping: ☐ Light ☐ Moderate ☐ Heavy

LMP (1st day of last period): _____

At what age did you go through menopause?

CONTRACEPTIVES

Contraceptive method used now:

_____

What is your preferred pharmacy? _____

Most testing is sent to an outside lab. You will receive a separate bill from that lab for these services

Reviewed By: _____