GYN Medical History Questionnaire

Name_____ DOB _____ Date_____

Please answer all questions
What is the reason for seeing the Physician? _____
How long have you had this problem? _____
What treatment has been given to date? _____

CURRENT MEDICATIONS (include vitamins, mineral and herbs)

Name of Medication	Dosage (mg)	Number of Daily Doses	Purpose (medical condition treated)	Prescribing Physician

MEDICAL HISTORY (check all medical problems you currently have):
☐ Abnormal Pap Smear or Cervical Disease ☐ Cancer ☐ Diabetes ☐ Stroke ☐ Hepatitis
☐ Thromboembolic Disease (clots) Hypertension ☐ Meningitis ☐ Anemia ☐
☐ Irritable Bowel Disease ☐ Asthma ☐ Epilepsy ☐ Endometriosis
☐ Rheumatic Fever ☐ Abnormal Mammogram ☐
☐ Gastroesophageal Reflux Sexually-Transmitted Diseases _____
☐ Heart Disease Other_____ ☐ **None**

GYN HISTORY- please check all that apply
Periods: Normal ☐ Irregular ☐ Normal Blood Loss ☐ Heavy Blood Loss ☐ Pain Menopausal
Passage of Large Clots ☐ Bleeding After Sex or Between Periods ☐ Menopausal Prolonged Bleeding
How often do you have a period. ☐ Monthly☐ every 28 days☐ other_____
Date of last menstrual period _____
If you are pregnant have you had an Ultrasound? Y N Date_____ Facility_____
Age when menstrual periods began _____ years old.
Sexual Activity Active ☐ Not Currently Active ☐ Single Partner ☐ Other _____
Date of Last Pap Smear _____ Was it normal? _____
Date of Last Mammogram _____Was it normal?_____
Date of Abnormal Pap Smear_____ Never
Hysterectomy? Yes Date: _____ No
Infertility? Yes No Polycystic Ovarian Syndrome? Yes No
What were/are you using for contraception? _____ ☐ **None**
Positive Urine Pregnancy Test? Yes No Date of first home or doctor's office pregnancy test_____
Adopted Children_____
Date of Last Dexa Bone Scan _____ Was it normal?_____

ALLERGIES (Please List)_____ _____ **None**

OB HISTORY

Total Pregnancies	
Total Living Children	
Stillbirths	
Miscarriages	
Abortions	
Delivery dates/Type of delivery/Sex	
Ectopic	
Premature	

SURGICAL HISTORY

Month and Year	**Surgery**

HOSPITALIZATIONS

Month and Year	**Reason**

FAMILY HISTORY

Family Member	**Status: alive or deceased**	**Age**	**Indicate any medical problems: cancer, diabetes, stroke, high blood pressure, kidney disease, birth defects, etc.**
Father			
Mother			
Paternal Grand Father			
Paternal Grand Mother			
Maternal Grand Father			
Maternal Grand Mother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			
Brother (How many)			
Sister (How many)			
Son			
Daughter			

SOCIAL HISTORY

Do you smoke? No	Yes Packs Per Day_____ Years_____
Illegal drug use? No	Yes Current Use_____ Past Use_____
Exercise? No	Yes Type_____ How Often_____
Caffeine? No	Yes Type_____ Daily Amount_____
Alcohol? No	Yes Type_____ How Often _____ Years_____
Occupation?	