Date_____

Name_____ DOB_____

Reason for today's appointment_____

Medications:	Allergies:

GYN History:

Age at first period: _____

Date of last menstrual period: _____

Last menstrual period: Unknown/Approximate/Definite

Do you have monthly periods? Yes No

Flow: Light/Moderate/Heavy How many days does your period last? _____

Painful periods? Yes No Bleeding between periods? Yes No

Are you menopausal? Age at menopause _____

Are you taking Hormone Therapy? Yes No

Any bleeding after menopause? Yes No

Are you currently sexually active? Yes No Do you have sex with: Men Women Both

# of lifetime sexual partners ____

Are you currently safe at home? Yes No

Painful sex? Yes No

Have you ever had a STD/STI? Yes No _____

Have you received the HPV Vaccine Yes No

Have you ever had an Abnormal Pap smear? Yes No

Current birth control method _____

Past birth control methods_____

What % of the time do you use condoms? _____

Date of your most recent Pap smear	
Date of your most recent Mammogram	

Date of your most recent Bone Density	
Date of your most recent Colonoscopy	

Surgical History:

Procedure	Date

Obstetric History:

How many total pregnancies have you had? _____

Full Term deliveries _____Premature deliveries _____ Abortions_____ Miscarriages _____ Ectopic_____

Did you ever have twins or triplets? _____

How many living children do you currently have? _____

Past Pregnancies:

Date of delivery # of weeks Baby's weight Type of Delivery Gender/name, problems?

_____

_____

_____

_____

_____

_____

Family History: Please indicate which relative:

DVT/PE	
Stroke	
Diabetes	
Thyroid problem	
Heart disease	
High cholesterol	
Heart attack	

Breast cancer	
Cervix cancer	
Colon cancer	
Lung cancer	
Ovarian cancer	
Uterine cancer	
Osteoporosis	

Social History:

Are you currently employed? _____occupation_____

Education_____relationship status_____

Have you ever been a victim of physical/sexual abuse? _____

How much do you exercise? _____

Smoking Status Never/Former/occasional smoker/everyday smoker

How much do you smoke? _____

How many years have you smoked _____

Caffeine intake Yes No

Recreational drugs? Never/Current/Past Drug of choice_____

Alcohol use? None/occasional/moderate/heavy how much? _____ how often? _____

Is blood transfusion acceptable in an emergency? Yes No Do you have advance directives? Yes N

Past Medical History: Please check if you have now or have ever had any of the following problems.

	Yes	No
Migraine with flashing lights		
Migraine headache		
Blood clots (DVT/PE) in legs, arms or lungs		
Factor V Leiden / Prothrombin		
Lupus		
Antiphospholipid antibody syndrome		
Epilepsy / seizure disorder		
High blood pressure		
High cholesterol/triglycerides		
Heart attack		
Heart rate irregularities/arrhythmia		
Stroke		
Heart disease		
Mitral valve prolapse or Aortic stenosis		
Asthma		
COPD		
Sleep apnea		
Tuberculosis		
Dermatology disorder		
Malabsorption (Celiac, gastric stapling/surgery)		
Fibromyalgia		
Multiple sclerosis		
Acid reflux/GERD		
Gallstones		
Pancreatitis		
Alcoholic hepatitis		
Hepatitis A, B or C		
Cirrhosis		
Irritable bowel syndrome		
Crohn's or ulcerative colitis		
Kidney failure/insufficiency		
Diabetes		
Hypothyroid		
Hyperthyroid		
Hashimoto's thyroiditis		
Graves' Disease		
Osteopenia		
Osteoporosis		

	Yes	No
Arthritis – osteoarthritis		
Arthritis - rheumatoid		
PCOS / Metabolic syndrome		
Depression (Postpartum Depression) / Anxiety		
Bipolar disorder		
Mental illness /Schizophrenia		
Cervix cancer/dysplasia		
Breast cancer		
Fibrocystic breasts/Benign breast disorder		
Uterine cancer		
Ovarian cancer		
Melanoma		
Basal or squamous cell skin cancer		
Thyroid cancer		
Lymphoma/Leukemia		
Overactive bladder		
Leaking urine		
Recurrent bladder infections		
Interstitial cystitis/painful bladder		
BRCA carrier positive		
LYNCH syndrome carrier positive		
Cystic fibrosis carrier		
Genetic / inherited problem		
Cerebral palsy		
Developmental delay		
Anemia/Sickle cell/ thalassemia		
Neural tube defect / spina bifida		
HIV		
Herpes genital		
Herpes oral		
Syphilis		
PID		
Endometriosis		
Uterine hyperplasia		
Fibroids		
Ovarian tumors/cysts		
Infertility		
Recurrent pregnancy loss		
History of a blood transfusion		
Complications with anesthesia		

Menstrual History:

When was your Last Menstrual Period? _____ Are your periods monthly Yes No

Frequency (Days) _____ Age Periods Started _____

Were you on birth control when you conceived? Yes No

Date you found out you were pregnant with a pregnancy test _____

Genetic screening history	Yes	No
Patients Age Will Be 35 Years or Older At Time Of Delivery		
Thalassemia (Italian, Greek, Mediterranean Or Asian Background		
Hemoglobinopathy Or Carrier		
Neural Tube Defect (Meningomyelocele, Spina Bifida Or Anencephaly		
Congenital Heart Defect		
Down Syndrome		
Tay-Sachs (Jewish, Cajun, French-Canadian		
Canavan Disease		
Sickle Cell Disease or Trait (African)		
Hemophilia Or Other Blood Disorders		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's Chorea		
Intellectual Disability/ Autism		
If Yes, Was Person Tested For Fragile X?		
Other Inherited or Chromosomal Disorders		
Chromosomal Disorder		
Other Structural Birth Defect		
Patient Or Baby's Father Had A Child With Birth Defects Not Listed Above		
Recurrent Pregnancy Loss Or A Still Birth		
Maternal Metabolic Disorder (Type 1 Diabetes, PKU)		

Infection history	Yes	No
Live With Someone With TB or Exposed		
Patient Or Partner Has History Of Genital Herpes		
History Of STD, Gonorrhea, Chlamydia HPV, Syphilis		
History Of HIV		
History Of Hepatitis		
Other Infection History		
Recent Travel Outside Of The Country		