

MEDICAL HISTORY INFORMATION SHEET

Name _____

Today's date _____

Any concerns/issues you would like to discuss today?

Age _____ Date of birth _____

GYNECOLOGY HISTORY **G** **P**

First day of last menstrual period?	
Age at 1st period	
# of days between periods (from 1st day of period to 1st day of next period)	
Length of period (# of days of bleeding)	
Heavy bleeding?	Y / N
Cramps?	Y / N

Birth control method <input type="checkbox"/> N/A	
Number of sexual partners in last year	
Are you currently sexually active?	Y / N
Have you had any sexually transmitted diseases? If yes, which ones?	Y / N
Would you like to be tested today?	Y / N

When was your last pap smear?	
Any history of abnormal pap smears? When was this? What treatment was performed?	Y / N
When was your last mammogram? <input type="checkbox"/> N/A	
Any history of abnormal mammograms?	Y / N
Do you do self-breast exams?	Y / N

Any history of sexual abuse or domestic violence?	Y / N
Would you like to talk about this today?	Y / N

If you are in menopause:

When did this begin?	
Which hormone replacement therapy are you taking? <input type="checkbox"/> N/A	
What symptoms are you having? Please circle Hot flashes Vaginal dryness Night sweats Vaginal bleeding Low libido Insomnia Mood changes	

OBSTETRIC HISTORY - No changes
List all previous pregnancies

PAST MEDICAL HISTORY - No changes
List all medical problems

PAST SURGICAL HISTORY - No changes
List all previous surgeries

Please bring this information sheet with you when you arrive for your appointment.

MEDICATIONS

List all medications, herbs or supplements

ALLERGIES

SOCIAL HISTORY- Do you do any of the following:

Marital status			
Smoke?	Y / N	How many packs a day?	
Drink alcohol?	Y / N	How many drinks a week?	
Do drugs?	Y / N	Which drugs?	

FAMILY HISTORY-Please circle if you have any family members with the following:

- Breast cancer Uterine cancer Ovarian cancer
- Colon cancer Stroke High blood pressure
- Heart attacks Blood clots Diabetes
- Osteoporosis Birth defects Other:

PREVENTATIVE

Do you exercise?	Y / N	What kind and how often?	
Use sunscreen?	Y / N		
Use a seatbelt?	Y / N		
Calcium in your diet?	Y / N		

Have you had the following test? When was this test last done?

Cholesterol (≥45 y/o, q5y)	
Diabetes (≥45y/o, q3y)	
Thyroid	
Colonoscopy (≥50y/o, q10y)	
Bone density	

REVIEW OF SYSTEMS- Please circle if you have any of the following

- NONE OF THE BELOW
- Fever Fatigue Hair loss
- Chest pain Cough Shortness of breath
- Palpitations Feeling hot/cold
- Breast pain Breast lump Nipple discharge
- Diarrhea Constipation Blood in stools
- Pain with urination Frequent urination
- Urge to urinate Blood in urine
- Loss of urine/incontinence Change in height
- Cuts that don't stop bleeding Weight loss/gain