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**GYN Medical History**

Name \_\_\_\_\_ Date \_\_\_\_\_ Chart No. \_\_\_\_\_

I authorize this information is true & accurate: \_\_\_\_\_  
Patient Signature

**Menstrual History**

1. What are the dates of your last 2 menstrual periods? 1. \_\_\_\_\_ 2. \_\_\_\_\_
2. How many days does your period normally last? \_\_\_\_\_ is flow: \_\_\_Light \_\_\_Moderate \_\_\_Heavy
3. How many days between periods? (Count from start of period to start of next period) \_\_\_\_\_
4. Pain or cramps? \_\_\_Y \_\_\_N if yes, when in cycle, and what medications: \_\_\_\_\_
5. How old were you when you had your first period? \_\_\_\_\_

**Obstetrical History**

Number of Pregnancies\_\_\_\_ Full Term\_\_\_\_ Premature\_\_\_\_ Miscarriages\_\_\_\_ Abortions\_\_\_\_

Please list each pregnancy, including all information such as type delivery (vaginal or c-section), and include sex and condition of baby. Include miscarriages and abortions.

<u>Date</u>	<u>Place</u>	<u>Type (vag, c-sec,etc)</u>	<u>Anesthesia</u>	<u>Labor</u>	<u>Complications</u>	<u>Wt.</u>	<u>Baby</u>
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**Past Medical History**

**Allergies** to medicines/anesthetics/Latex: \_\_\_\_\_

If yes, what sort of reaction did you have? \_\_\_\_\_

Are you being treated for any illnesses or conditions by any other physician? \_\_\_Y \_\_\_N

If yes, explain: \_\_\_\_\_

Are you currently taking any medications, including birth control pills/hormones? \_\_\_Y \_\_\_N

If yes, please list: \_\_\_\_\_

Do you smoke cigarettes? \_\_\_Y \_\_\_N ... if yes, how many per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_Y \_\_\_N ... if yes, how much per day? \_\_\_\_\_

Have you ever used illicit drugs? \_\_\_Y \_\_\_N... if yes, explain: \_\_\_\_\_

Ever had blood transfusion \_\_\_Y \_\_\_N ... if yes, when? \_\_\_\_\_

Please list all non-Obstetrical hospitalizations, surgeries, and outpatient surgeries.

<u>Date</u>	<u>Place</u>	<u>Diagnosis</u>	<u>describe Surgery or Medical Care</u>	<u>M.D.</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever had any of the following?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	Hepatitis	___	___	Kidney or Bladder problems
___	___	Chickenpox	___	___	Thyroid Disease
___	___	Cancer	___	___	Blood Clots in legs or lungs
___	___	Migraines	___	___	Seizures
___	___	High Blood Pressure	___	___	Mental Problems or depression
___	___	Diabetes	___	___	Blood Diseases
___	___	Heart Disease	___	___	Endometriosis
___	___	Lung Disease	___	___	Bleeding Disorders
___	___	Sexually Transmitted Infections (if yes, list which _____)			

Do you perform monthly self-breast exam? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_ Result \_\_\_\_\_

Do you check your skin regularly for any abnormalities? \_\_\_\_\_

Have you had a tetanus shot in the last 10 years? \_\_\_\_\_

Are you considering pregnancy in the future? \_\_\_\_\_

*If yes, have you had or been vaccinated against chicken pox? \_\_\_\_\_*

And are you immune to German measles (Rubella)? \_\_\_\_\_

Have you had a cholesterol test in the last 5 years? \_\_\_\_\_ .... If yes, When \_\_\_\_\_ Result \_\_\_\_\_

Do you wear seat belts? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_

**Family History**

Has anyone in your family ever had any of the following?

Allergic Reactions to medications/anesthetics or reaction to anesthesia \_\_\_\_\_

Cancer (list relative and type of cancer) \_\_\_\_\_

Heart Disease before age 55 \_\_\_\_\_

High Blood Pressure or Stroke \_\_\_\_\_

Diabetes \_\_\_\_\_

Endometriosis, Uterine Fibroids \_\_\_\_\_

Bleeding Disorders \_\_\_\_\_

Any other medical problems \_\_\_\_\_

**Review of Systems** (Please circle if you currently have any of the following).

General Symptoms: Fever, sweats, fatigue, eating disorder, significant weight change.

Skin: Change in moles, new moles, skin lesions

Eyes: Change in vision, problem requiring visit to a physician.

Breasts: Lumps, pain, swelling, discharge, blood, trauma.

Respiratory System: Unexplained cough, coughing blood, wheezing, pain.

Cardiovascular System: Chest pain, short of breath (with exertion or not), palpitations, irregular.

Gastrointestinal System: Unexplained nausea, vomiting, vomit blood, constipation, diarrhea, pain, change in bowel habits, change in stool color (tarry, bloody), abdominal pain or jaundice.

Genitourinary System: Lose urine with cough/sneeze, urinate more frequently, bloody urine, pain.

Reproductive System: Abnormal bleed, pelvic pain, sexual dysfunction/pain, vaginal discharge, itching, burning

Musculoskeletal System: Joint pain, swelling, muscle, weakness, trauma, fracture.

Lymph Nodes: Enlargements or pain.

Nervous System: Numb or sensory change, paralysis, weakness, new headache, feeling depressed or mood problems