GYNECOLOGIC HISTORY

Single _________ Divorced _______

NAME ____ DATE _________________ AGE __________ Married ________ Widow _________

Religious Preference ___________________________

Date of last physical examination ____ Referred by ___________________

Problems you wish to discuss with the Doctor:

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Routine check-up: Yes____ No____

Date of last menstrual period ___________________________________ How many pregnancies have you had? __________________________

Full 9 month _____ Premature _____ Abortions (Miscarriage) ______ Number of Living Children _____

Any complications during pregnancy, labor, delivery, or post partum period? ____

____

What are you using for birth control:

Nothing _____ Pill ______ Vasectomy/Hysterectomy _____ Rhythm _____ IUD _____

Tubal Ligation _____ Diaphragm _____ Other ________________________________

Allergies to Medicines:

1. ___________________________ 3. ___________________________
2. ___________________________ 4. ___________________________

Current Medications:

1. ________________________ 3. ________________________
2. ________________________ 4. ________________________

	Age	If Living Health	Age at Death	If Deceased Cause	Has any blood relative ever had	Please Circle	Which Relative
Father					Breast Cancer	Yes No	
Mother					Diabetes	Yes No	
Brother or Sister 1					Tuberculosis	Yes No	
2					Cancer	Yes No	
3					High Blood P.	Yes No	
4					Heart Disease	Yes No	
5					Kidney Disease	Yes No	
Husband					Hepatitis	Yes No	
Children 1					Alcoholism	Yes No	
2					Drug Addiction	Yes No	
3					Mental Dis.	Yes No	
4					Venereal Dis.	Yes No	
5					Peptic Ulcer	Yes No	

PERSONAL HISTORY

Have you ever had:

German Measles ____
Rheumatic Fever ____
Heart Murmur ____
Gonorrhea ____
Syphilis ____
Genital Herpes Virus ____
Anemia ____
Gallbladder Disease ____
Jaundice ____
Hepatitis ____

Epilepsy ____
Migraine Headaches ____
Tuberculosis ____
Diabetes ____
Cancer ____
Hi Blood Pressure _____ Take Medicine Yes ____ No ____
Hemorrhoids ____
Sinus Trouble ____
Asthma ____

Have you ever had:

Blood clot in legs ______________________ Kidney Disease ______________________

Bladder infection ______________________ Infection in womb or tubes______________________

Have you ever been injured seriously?

How______________________ When ______________________

What injuries sustained ______________________

____

____

Weight now______________________ One year ago ______________________

Maximum weight? ______________________ When ______________________

List all Surgery you have had:	Date	List all illnesses which required hospitalization	Date
Type: 1. ______________________		______________________	
2. ______________________		______________________	
3. ______________________		______________________	
4. ______________________		______________________	

Have you ever had a blood transfusion?______________________

____

Have you ever had anything wrong with your Lungs ______________________

Heart______________________

Kidneys______________________

Do you have now or have you had within the past year:	YES	NO
Uncontrollable loss of urine when coughing or sneezing?	______	______
Unvontrollable loss of urine when bladder full?	______	______
Uncontrollable loss of urine after emptying bladder?	______	______
Uncontrollable loss of urine when you feel urge to urinate?	______	______
Uncontrollable loss of urine when sitting, standing or lying quietly?	______	______
Have you had a sensation of stool bulging into birth canal when you have a bowel movement?	______	______
Have you ever had to express stool from rectum by placing fingers in vagina?	______	______
Sensation of female organs dropping into birth canal?	______	______
Are these above symptoms a problem to you?	______	______

Pain on Intercourse:

Do you consider your sexual relationship satisfactory?	______	______
Can you reach climax during intercourse?	______	______

Do you have any pain with your periods?

Starts ___________ days before flow starts . . . . . ______ ______

How old were you when your menses started? ________________

How many days between your periods? ________________

Are periods regular? . . . . . ______ ______

How many days of menstrual flow? ________________

Periods: Heavey _____ Medium _____ Light _____

Pass any clots in menstrual flow? . . . . . ______ ______

Date of last menses? ______________________

Date of last pelvic exam? ______________________

Date of last PAP smear?______________________

Date of last breast exam?______________________

Have you ever had an abnormal PAP smear? . . . . . ______ ______