GYNECOLOGICAL HISTORY

NAME: _____ Date of Birth: _____ DATE: _____

First Day of your last (or current) period: _____

How may days does your period last? _____

How may days are there between your periods? _____

Do you have:
__ Painful periods
__ Unusual discharge/infections
__ Spotting between periods
__ Missed periods

Date of your last Pap smear. _____

Ever had an abnormal Pap smear? _____

Are you sexually active? _____

List any sexually transmitted diseases you have had.
_____

Do you use condoms for STD protection? _____

What contraceptive methods are you currently using? Check all that apply.

____Abstinence ____ Partner had vasectomy
____ Condoms ____Tubal ligation
____ Depo Provera ____Nuva Ring
____ Patch ____ Nothing
____ Pill/Name of Pill _____
____ Other/List what you are using: _____

Indicate number of:
____ Pregnancies ____ Live Births
____ Abortions ____ Miscarriages

List any biopsies, pelvic surgery or complications during pregnancy or delivery.
_____

Do you do monthly self-breast exams? _____

Do you know how to examine your breasts? _____

Do you:
- smoke? _____
- drink alcohol? _____
- exercise? _____

FAMILY HISTORY

Have any of your immediate family (mother, father, sisters, brothers) ever had:

__ Blood clots/phlebitis
__ Breast cancer
__ Diabetes
__ Heart Attack
__ High blood pressure
__ High cholesterol
__ Stroke

YOUR MEDICAL HISTORY

Have you ever had:

__ Anemia
__ Asthma
__ Blood clots/phlebitis
__ Depression
__ Diabetes
__ Epilepsy
__ Heart disease
__ High cholesterol
__ Jaundice
__ Kidney/bladder infection
__ Liver disease
__ Migraine headaches
__ Thyroid disease
__ Uterus or tube infection
__ Varicose veins

__ Surgery, type: _____
_____
_____