PATIENT IDENTIFICATION

Patient's name _____

Gynecology Health History

Date:

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Age____ Race_____ Education_____ Occupation_____ Referring Physician _____

Reason for seeing doctor:

Past Medical History

	Patient	Family
1. Headaches or a nervous disorder	☐	
2. A thyroid problem	☐	
3. A heart condition or high blood pressure	☐	☐
4. A lung disorder	☐	☐
5. Breast problems	☐	☐
6. Jaundice, hepatitis, or other liver disorders	☐	☐
7. Stomach, bowel or gallbladder problems	☐	
8. Kidney or bladder problems	☐	
9. Female or sexual problems	☐	
10. Allergies or drug sensitivities	☐	☐
11. Anemia or blood disorders	☐	☐
12. A blood transfusion	☐	
13. Diabetes	☐	☐
14. Cancer	☐	☐
15. Birth defects or inherited diseases	☐	☐
16. Other medical problems	☐	☐
17. Presently taking medications	☐	

18. Hospitalizations (Check box ☐ if more than four)

Mo/yr	Illness or operation	Complications No	Complications Yes
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

19. Obstetrical History Please list the number of: Times pregnant_____

Premature births | Mis-carriages | Abortions | Living children

No.	Born mo/yr	Weight at birth	Baby's sex	Weeks preg.	Type of delivery	Complications No	Complications Yes
1	/	lb oz				☐	☐
2	/	lb oz				☐	☐
3	/	lb oz				☐	☐
4	/	lb oz				☐	☐
5	/	lb oz				☐	☐

20. Menstrual History

LMP month / day / year ☐ Abnormal bleeding

Onset age ☐ Pain

Cycle days ☐ Leukorrhea

Length days

Amount per heaviest day pads tampons

22. Family Planning

	Past	Pres
Oral contraceptive:	☐	☐
IUD	☐	☐
Diaphragm	☐	☐
Other	☐	☐

Sterilization: ☐ Male ☐ Female

Infertility: ☐ Yes ☐ No

Duration: _____

21. Sexual History

	Yes	No
Sexually active:	☐	☐
Frequency: ____times per_____		
Satisfied:	☐	☐
Dyspareunia:	☐	☐

23. Marital History

☐ Married ☐ Single

No. of years_____ ☐ Sep.

☐ Divorced

No. of times_____ ☐ Widowed

Check and detail all findings below. Use reference numbers.

Signature: