



**MEDICAL HISTORY INFORMATION SHEET**

Name, \_\_\_\_\_

Any concerns/issues you would like to discuss today?

**MEDICATIONS**

List all medications, herbs or supplements

**ALLERGIES to any medicines**

**GYNECOLOGY HISTORY**

**G P**

First day of last menstrual period?	
Age at 1 <sup>st</sup> period?	
# of days between periods (from 1 <sup>st</sup> day of period to 1 <sup>st</sup> day of next period)	
Length of Period (# of days bleeding)	
Heavy Bleeding?	Y/N
Cramps?	Y/N
Birth Control Method	
Number of sexual partners in the last year	
Are you currently sexually active?	Y/N
With whom do you have sex? Males only/females only/both males and females	
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? N/A	

Any history of sexual abuse or domestic violence?	Y/N
Do you feel safe in your current relationship?	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? N/A	
What symptoms are you having? Please circle Hot flashes      Vaginal dryness      Night sweats Vaginal bleeding      Low libido      Insomnia Mood changes	

**OBSTETRIC HISTORY-**

List all previous pregnancies

**PAST MEDICAL HISTORY**

List all medical problems

**PAST SURGICAL HISTORY**

List all previous surgeries

Marital status			
Occupation?			
With whom do you live?			
Smoke?	Y/N	How many packs a day?	
Drink alcohol?	Y/N	How many drinks a week?	
Do drugs?	Y/N	Which drugs?	
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		
Had the HPV vaccine? (if you are 26 or younger)	Y/N	If not, would you like this?	Y/N

**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 disease | Blood clots    | Diabetes            |
| Osteoporosis  | Birth defects  | Other:              |

**Preventative**

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

Cholesterol	
Diabetes	
Thyroid	
Colonoscopy	
Bone density	

**REVIEW OF SYSTEMS-** Please circle

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       | Nausea/ vomiting   |
| Pain with urination           | Frequent urination    |                    |
| Urge to urinate               | Blood in urine        |                    |
| Loss of urine/incontinence    | Change in height      | Sleep difficulties |
| Cuts that don't stop bleeding | Weight loss/gain      |                    |
| Rashes or skin lesions        | Depression or anxiety |                    |