GYN FORM

Patient Name: Date:

Past Medical History

Please put a check beside all that apply to you

☐ Anemia	☐ Endometriosis	☐ Kidney Disease
☐ Anesthesia Complications	☐ GI problems	☐ Lung Disease
☐ Anxiety Disorder	☐ Glaucoma	☐ Nasal allergies
☐ Arthritis	☐ Headaches or Migraines	☐ Ovarian cancer
☐ Asthma	☐ Heart Conditions	☐ Psychiatric illness
☐ Birth defects or inherited disease	☐ Heart Disease	☐ Thyroid problems
☐ Breast Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Breast Problems	☐ High blood pressure	☐ Varicosities
☐ Cancer	☐ Hypertension	
☐ Depression	☐ Infertility	
☐ Diabetes		

GYN History

Please answer the questions below

Date of last menstrual period _____

How many days do you bleed? _____

Do you have periods every month? _____

How many days apart are your periods? _____

Is your period normally light, moderate or heavy? _____

Age at first child _____

Age at menarche _____

Current birth control method:

_____

Were you on BCP's at conception? _____

If post-menopausal, age at menopause

_____

Last Pap Smear?

_____

Last Mammogram?

_____

Obstetrical History

Please list all pregnancies you have had including miscarriages, terminations and ectopic pregnancies.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgical History

Please list all surgical procedures you have had and the years they were performed

1. _____
2. _____
3. _____
4, _____
5. _____
6. _____
7. _____
8, _____
9, _____
10. _____

Family History

Do any family members have any of these conditions? If so who?

	Parents	Siblings	Aunts	Uncles	Cousins	Grand Parents
Alcoholism						
Arthritis						
Asthma						
Bleeds easily						
Cancer (type)						
Diabetes						
Drug Abuse						
Epilepsy						

GYN FORM

		Parents	Siblings	Aunts	Uncles	Cousins	Grand Parents
	Heart Disease						
	High Cholesterol						
	High Blood Pressure						
	Kidney Disease/Stones						
	Mental Illness						
	Obesity						
	Osteoporosis						
	Stroke						
	Suicide						
	Thyroid Disease						

Social History

Occupation: _____

Education: _____

General Stress Level: ☐ Low ☐ Medium ☐ High

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Began ☐ Gluten Free ☐ Specific Carbohydrate or Cardiac

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Unknown

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Smoking Status: ☐ Never Smoked ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker

Smoking How Much: ☐ None ☐ 1 PPW ☐ 2 PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 1 ½ PPD ☐ 2 PPD ☐ 3+ PPD

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Any Past Use of Illicit Drugs: ☐ Yes ☐ No

Sexually Active: ☐ Yes ☐ No

Assigned Sex at Birth: ☐ Female ☐ Male

Current Medications (including vitamins, herbs and over- the- counter) If you need additional space please use back of form

MEDICATION NAME	DOSAGE

Do you have any known Allergies to Medication? ☐ Yes ☐ No

If so, please list medication and reaction: _____

_____

SIGNATURE: _____ DATE: _____