WOMEN'S HEALTH CARE
At Frost Street, A.M.C.
Obstetrics & Gynecology

PATIENT NAME:____________________ **DATE:**__________
DATE OF BIRTH:__________ **AGE:**_____ **ALLERGIES:**__________
OCCUPATION:____________________ **MARITAL STATUS:**__________
Problems you would like to discuss today:____________________

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY:

FIRST DAY OF LAST PERIOD:__________ FREQUENCY OF PERIODS:__________DAYS
LENGTH OF PERIODS:__________DAYS # OF PADS/TAMPONS USED ON HEAVIEST DAYS:_____

PAP SMEARS:

DATE OF LAST PAP SMEAR:__________ RESULT OF LAST PAP SMEAR:__________

BIRTH CONTROL:

TYPE USED, IF SEXUALLY ACTIVE:____________________ EVER USE AN IUD?__________

BREASTS:

DATE OF LAST MAMMOGRAM:__________ RESULT:__________

Have you ever experienced the following:	**NO**	**YES**	**DETAILS/DATES**
PAINFUL PERIODS	☐	☐	
IRREGULAR CYCLES	☐	☐	
BLEEDING BETWEEN PERIODS	☐	☐	
BLEEDING AFTER INTERCOURSE	☐	☐	
LARGE CLOTS WITH PERIODS	☐	☐	
ABNORMAL PAP SMEARS	☐	☐	
BREAST ASPIRATION OR BIOPSY	☐	☐	
INFERTILITY TREATMENT	☐	☐	
SEXUALLY TRANSMITTED DISEASE	☐	☐	
(HERPES, WARTS, GONORRHEA,	☐	☐	
CHLAMYDIA, PELVIC INFECTION)	☐	☐	
DO YOU WANT TO BE TESTED FOR ANY			
SEXUALLY TRANSMITTED DISEASES?	☐	☐	
NEW SEXUAL PARTNERS SINCE LAST EXAM?	☐	☐	
PAIN OR PROBLEMS WITH INTERCOURSE	☐	☐	
PROBLEMS WITH UNEXPECTED LOSS OF URINE	☐	☐	
ENDOMETRIOSIS	☐	☐	
FIBROIDS	☐	☐	
OVARIAN CYSTS	☐	☐	

IS YOUR PARTNER MALE ________ OR FEMALE________.

OBSTETRICAL HISTORY: -List the date and outcome of all pregnancies, including miscarriages and abortions.

DATE:____________________

SURGICAL HISTORY: -List the date and type of procedure of all operations & hospitalizations:.

DATE:____________________

Patient Signature ____________________ **Reviewed by M.D.**____________________

MEDICAL HISTORY: - Have you ever had? (Check if yes):

- ☐ **HEART DISEASE?** ☐ HEART MURMUR ☐ HEART ATACK ☐ HIGH BLOOD PRESSURE ☐ CHEST PAIN ☐ PALPITATIONS (IRREGULAR HEART BEAT)
- ☐ **LUNG DISEASE?** ☐ SHORTNESS OF BREATH ☐ ASTHMA ☐ EMPHYSEMA ☐ TUBERCULOSIS
- ☐ **LIVER DISEASE?** ☐ HEPATITIS OR YELLOW JAUNDICE?
- ☐ **KIDNEY DISEASE?** ☐ URINARY TRACT OR KIDNEY INFECTIONS ☐ KIDNEY STONES
- ☐ **GASTRONINTESTINAL PROBLEMS?** ☐ CHRONIC CONSTIPATION/DIARRHEA ☐ ULCERS ☐ BLOODY STOOLS
- ☐ **NERVOUS SYSTEM PROBLEMS?** ☐ STROKES ☐ SEIZURES (EPILEPSY) ☐ HEADACHES/MIGRAINES ☐ FAINTING ☐ NERVE PARALYSIS ☐ DEPRESSION ☐ EATING DISORDERS
- ☐ **BLOOD DISORDERS?** ☐ BLEEDING DISORDERS ☐ BLOOD CLOTS IN LEGS OR LUNGS ☐ VARICOSE VEINS ☐ EASY BRUSING ☐ SICKLE CELL ☐ ANEMIA
- ☐ **METABOLIC DISEASE?** ☐ THYROID DISEASE ☐ DIABETES ☐ HIGH CHOLESTROL
- ☐ **MUSCLE & BONE DISEASE?** ☐ ARTHRITIS ☐ CONSTANT BACK PAIN ☐ OSTEOPOROSIS
- ☐ **SKIN DISEASE?** ☐ SKIN CANCER ☐ MELANOMA ☐ ABNORMAL MOLES
- ☐ **AUTOIMMUNE DISEASE?** ☐ LUPUS ☐ ____________________

DO YOU DRINK ALCOHOL?________________ HOW MUCH?________________________

DO YOU SMOKE?________ HOW MUCH?__________________ IF NO, HAVE YOU EVER SMOKED?______

DO YOU USE RECREATIONAL DRUGS? ______________________________________

ANY PROBLEMS WITH ALCOHOL OR DRUGS?______________________________________

ANY HISTORY OF AN ABUSIVE RELATIONSHIP?____________________________________

DO YOU WISH TO DISCUSS YOUR HIV (AIDS) RISK? ______________________________

(RISK FACTORS: IV DRUGS, BLOOD TRANSFUSIONS, PARTNER WITH UNKNOWN HISTORY, RECTAL INTERCOURSE).

MEDICATIONS: - List all medications and dosages; list prescription, over the counter and herbal remedies used on a regular basis.

Medication: Dosage:

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FAMILY HISTORY: - Any family member with the following problems? If so, list relative.

	NO	YES	DESCRIBE
CANCER OF THE BREAST	☐	☐	______________
CANCER OF THE OVARY	☐	☐	______________
CANCER OF THE COLON	☐	☐	______________
CANCER - OTHER TYPES	☐	☐	______________
HIGH BLOOD PRESSURE	☐	☐	______________
HEART DISEASE OR HEART ATTACK	☐	☐	______________
DIABETES	☐	☐	______________
STROKE	☐	☐	______________
BLOOD CLOT IN LUNGS OR LEGS	☐	☐	______________
BLEEDING TENDENCY	☐	☐	______________

Patient Signature ______________________ **Reviewed by**____________________________**M.D.**