Gynecologic History continued

What contraception do you use? (How do you prevent pregnancy) ____________________

Please list all forms of contraception you have used in the past. ____________________

____

Have you had any complications from using any forms of contraception? Which ones and what happened?

____

Obstetrical History (Please list each pregnancy and the requested information)

Total Pregnancies ________ Term Births ________ Preterm (<5lb, 9oz) ________ Living Children ________

Miscarriages ________ Abortions ________ Ectopics (Tubal pregnancy) ________

Date	Wks. Gestation	Vaginal or C-Section	Weight of Baby	Male | Female	Complications

Have you had, or do you have:	No	Yes	Explain
Thyroid problems	☐	☐	
Diabetes	☐	☐	
Asthma	☐	☐	
Blood Clots	☐	☐	When?
High Blood Pressure (hypertension)	☐	☐	
Heart Problems	☐	☐	Which?
High Cholesterol (hyperlipidermia)	☐	☐	
Ulcer Disease	☐	☐	
Hepatitis	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Kidney Stones	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
Anemia (low blood count)	☐	☐	
Blood Clotting Disorder	☐	☐	
Previous Blood Transfusion	☐	☐	Why?
Sickle Cell Disease	☐	☐	
Arthritis	☐	☐	
Other medical problems	☐	☐	

Do you object to having blood or blood products? ____________________

Last colonoscopy: ________________ Findings: ____________________

Who is your Primary Care Provider? ____________________

Surgical/Hospitalization History

Date	Illness or Operation	Hospital/Physician	Complications

Medication Allergies

Medication	Reaction

Current Medication (Please include all over-the-counter and non-prescription drugs)

Drug	Dosage	Frequency

Social History

	No	Yes	How Much/How Often
Do you smoke cigarettes?	☐	☐	___
Do you drink alcohol?	☐	☐	___
Do you exercise?	☐	☐	___
Do you perform self breast exams?	☐	☐	___
Recreational drug use?	☐	☐	___

Review of Systems

General	No	Yes	Explain
Recent changes in weight	☐	☐	
Fever or chills	☐	☐	
Frequent night sweats	☐	☐	
Tiredness or fatigue	☐	☐	
Neurological			
Headaches/migraines	☐	☐	____________
Respiratory			
Shortness of breath	☐	☐	____________
Chronic cough	☐	☐	____________
Hematological			
Easy bruising	☐	☐	____________
Prolonged bleeding	☐	☐	____________
Eyes, Ears, Nose, Throat			
Visual problems	☐	☐	____________
Hearing problems	☐	☐	____________
Cardiovascular			
Limited exercise tolerance	☐	☐	____________
Chest pain or discomfort	☐	☐	____________
Palpitations	☐	☐	____________
Gastrointestinal			
Frequent vomiting	☐	☐	____________
Blood in stools	☐	☐	____________
Frequent heartburn/indigestion	☐	☐	____________
Frequent abdominal pain	☐	☐	____________
Diarrhea	☐	☐	____________
Constipation	☐	☐	____________
Skin			
Moles that are changing	☐	☐	____________
New moles	☐	☐	____________
Musculoskeletal			
Joint stiffness	☐	☐	____________
Joint pain	☐	☐	____________
Joint swelling	☐	☐	____________
Psychological			
Anxiety or panic attacks	☐	☐	____________
Depression	☐	☐	____________

IMPORTANT: You will need to address all your medical issues and concerns with your Primary Care Provider.

Family History

Anyone in the family with: Which family member? ______________________________

Heart disease ____________________

Sickle cell ____________________

Colon cancer ____________________

Breast cancer ____________________

Ovarian cancer ____________________

Other cancers (type)____________________

Diabetes ____________________

Birth defects ____________________

Hypertension ____________________

Psychiatric disorder ____________________

Clotting disorder ____________________

Tuberculosis ____________________

OFFICE USE ONLY

Ba ____________________

GH ____________________

Bp ____________________

PB ____________________

C ____________________

TVL ____________________

Hypermobility: YES NO

Stress Incontinence: YES NO

Supine Standing

Introitus: Gaping

Mildly Gaping

Nongaping

Reflexes: BC: ____________________

AW: ____________________

Atrophic: YES NO

RC: YES NO