



## Gynecological Patient Information

Welcome to our practice - we are glad you are here!

Appointment Date: \_\_\_\_\_ Appointment with (Doctor or Midwife): \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you ever been pregnant? Yes  No  How many times: \_\_\_\_\_

Number of Miscarriages: \_\_\_\_\_ Number of Terminations: \_\_\_\_\_ Number of Living Children: \_\_\_\_\_

Date of last Menstrual Period: \_\_\_\_\_ Age at first Period: \_\_\_\_\_ Age of Menopause: \_\_\_\_\_

Date of last Pap Smear: \_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_

Date of last Bone Density Screening: \_\_\_\_\_

What is your current birth control method? \_\_\_\_\_

The Pill \_\_\_\_\_ IUD \_\_\_\_\_ Tubal ligation \_\_\_\_\_ Hysterectomy \_\_\_\_\_ Vasectomy \_\_\_\_\_

Other: (describe) \_\_\_\_\_

Do you Smoke? Yes  No  If yes, how many cigarettes per day? \_\_\_\_\_

Do you consume Alcohol? Yes  No  If yes, how many drinks? Per day \_\_\_\_\_ Per week \_\_\_\_\_

Do you currently or have you ever used any Street Drugs? Yes  No

Do you consume Caffeine? Yes  No  If yes, how many cups per day? \_\_\_\_\_

Do you Exercise? Yes  No  If yes, how many times per week? \_\_\_\_\_

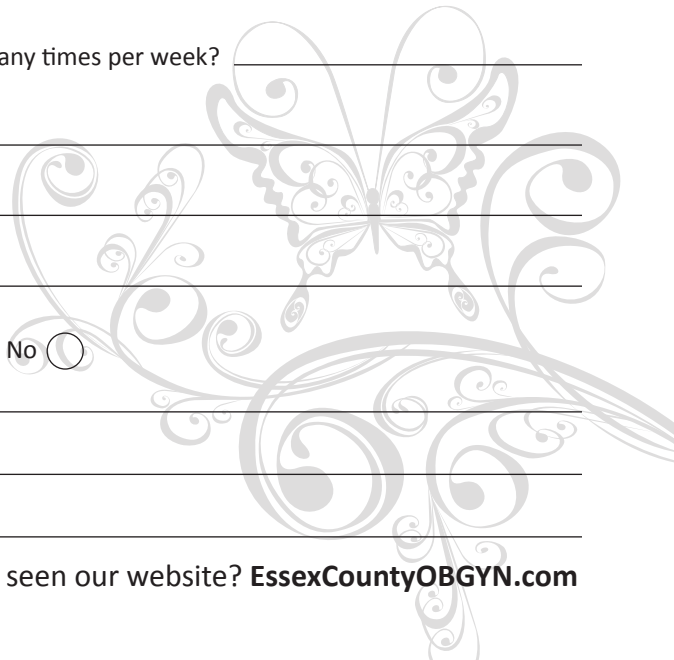
Current Medications: \_\_\_\_\_

\_\_\_\_\_

Do you have any Allergies? (Medications and Foods) Yes  No

If yes, please list them: \_\_\_\_\_

Pharmacy Name/Location: \_\_\_\_\_



**Gynecological Patient Form Page 2**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Have you ever had any of the following Gynecological/Obstetrical Surgeries? (Please check all that apply)**

- |   |  |   |   |                            |
|---|--|---|---|----------------------------|
| <input type="checkbox"/> Caesarean Section    | <input type="checkbox"/> ERS                 | <input type="checkbox"/> Ablation           | <input type="checkbox"/> LEEP                   |                            |
| <input type="checkbox"/> Essure               | <input type="checkbox"/> Pelviscopy          | <input type="checkbox"/> Ovarian Cystectomy | <input type="checkbox"/> Abdominal Hysterectomy |                            |
| <input type="checkbox"/> Vaginal Hysterectomy | <input type="checkbox"/> Laparoscopy         | <input type="checkbox"/> Tubal Ligation     | <input type="checkbox"/> Hysteroscopy           |                            |
| <input type="checkbox"/> D & C                | <input type="checkbox"/> Removal of Ovaries: | Right <input type="radio"/>                 | Left <input type="radio"/>                      | Both <input type="radio"/> |
| <input type="checkbox"/> Other: _____         |  |   |   |                            |

**Have you ever had any of the following? (Please check all that apply)**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Pap Smears         | <input type="checkbox"/> HPV                                | <input type="checkbox"/> Chlamydia                   | <input type="checkbox"/> Herpes              |
| <input type="checkbox"/> HIV                         | <input type="checkbox"/> Endometriosis                      | <input type="checkbox"/> Pelvic Inflammatory Disease |  |
| <input type="checkbox"/> Recurrent Miscarriage       | <input type="checkbox"/> Fibroid Uterus                     | <input type="checkbox"/> Recurrent Ovarian Cyst      | <input type="checkbox"/> Chronic Pelvic Pain |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Polycystic Ovarian Failure         | <input type="checkbox"/> Received HPV Vaccine        |  |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> High Blood Pressure (Hypertension) | <input type="checkbox"/> Heart Disease               |  |
| <input type="checkbox"/> Autoimmune Disease          | <input type="checkbox"/> Kidney Disease                     | <input type="checkbox"/> Pulmonary Disease (Asthma)  | <input type="checkbox"/> Breast Disease      |
| <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Hyperthyroidism                    | <input type="checkbox"/> Hypothyroidism              | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Varicosities                       | <input type="checkbox"/> Blood Transfusions          | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Other: _____                |   |  |  |

**Have you ever had any of the following other surgeries? (Please check all that apply)**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> Cholecystectomy (Removal of Gall Bladder) |  |  |
| <input type="checkbox"/> Other Abdominal: _____ |  |  |  |
| <input type="checkbox"/> Breast Augmentation    | <input type="checkbox"/> Breast Biopsy                             | <input type="checkbox"/> Breast Lumpectomy | <input type="checkbox"/> Breast Mastectomy |
| <input type="checkbox"/> Breast Reduction       | <input type="checkbox"/> Orthopedic:                               |  |  |
| <input type="checkbox"/> Cardiac: _____         |  |  | <input type="checkbox"/> Hernia            |
| <input type="checkbox"/> Other: _____           |  |  |  |

**Are any of the following diseases in your family? If yes, then who? (Please check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Breast Cancer: _____                             | <input type="checkbox"/> Ovarian Cancer: _____ |
| <input type="checkbox"/> Uterine Cancer: _____                            | <input type="checkbox"/> Colon Cancer: _____   |
| <input type="checkbox"/> Heart Disease: _____                             | <input type="checkbox"/> Diabetes: _____       |
| <input type="checkbox"/> Stroke: _____                                    | <input type="checkbox"/> Hypertension: _____   |
| <input type="checkbox"/> Mental Health or Behavioral Health Issues: _____ |  |
| <input type="checkbox"/> Other: _____                                     |  |

**Social History:**

- Marital Status:      Single       Married       Divorced       Widowed
- If you are single, are you currently involved in a relationship?    Yes     No        Male     Female     Both
- Do you have children?    Yes       No
- Are you employed?    Yes       No       Retired       Student       Stay-at-home mother

**Thank you.**