Austin Women's Clinic GYN History Form

Date: _____ SS No: _____ Marital Status:S/M/D/W Age: _____

Current Prescription Medications: _____

_____

Drug Allergies: _____

PERSONAL HISTORY: Have you ever had the following; if you check yes, please circle any appropriate response.

No	Yes	Unsure	
□	□	□	Is this your first pelvic exam? _____ If no, date of last exam_____
□	□	□	High Blood pressure
□	□	□	Diabetes
□	□	□	Cancer
□	□	□	Epilepsy, convulsions, fainting_____
□	□	□	Thyroid disease_____
□	□	□	Hormone problems including hirsutism (excess hair) _____
□	□	□	Heart Disease/murmur
□	□	□	Strokes/Blood clots_____
□	□	□	Blood problems (anemia, clotting problems, Sickle Cell etc.,)_____
□	□	□	High Cholesterol_____
□	□	□	Liver Disease (Hepatitis, Mononucleosis, Jaundice)_____
□	□	□	Urinary or bladder infections/Kidney problems_____
□	□	□	A serious illness? _____
□	□	□	Surgery? Type:_____
□	□	□	Hospitalization? _____ Dates:_____ Types:_____
□	□	□	Vaginal infections_____
□	□	□	Sexually transmitted Diseases: Gonorrhea, Syphilis, Genital Herpes, Chlamydia, Genital Warts, other_____
□	□	□	Pelvic infections (uterus, tubes, ovaries) or P.I.D _____
□	□	□	Pain or bleeding with intercourse_____
□	□	□	Date of Last Pap Smear_____.
□	□	□	Abnormal Pap(s)_____ Date(s) Done:_____
□	□	□	Breast problems (lumps, tumors, discharge, cysts)
□	□	□	Date of Last Mammogram _____

□	□	□	Abnormal Mammogram(s)_____ Date(s) Done:_____
□	□	□	Do you perform self breast examinations?
□	□	□	Date of Last Colonoscopy _____
□	□	□	Is your immunization current?
□	□	□	Psychiatrics/Emotional problems/depression_____ Medications:_____
□	□	□	Have you ever been emotionally or physically abused by your partner or someone important to you.
□	□	□	Do you participate in regular exercise programs? _____
□	□	□	Do you smoke? How much/day? _____
□	□	□	Do you consume alcohol? _____ Type? _____
□	□	□	Have you used drugs in the past or using now? _____ Type:_____ Dates:_____

MENSTRUAL HISTORY:

First day of the last menstrual period: _____. Was this normal: □ Yes □ NO.

Age periods began: _____. Periods come every _____ days and last _____ days.

Are periods: □ Light □ Moderate □ Heavy.

Have you ever
Missed periods? □ Yes □ No.

Had bleeding between periods? □ Yes □ No.

Had pain with periods (menstrual cramps) □ Yes □ No.

Taken medication for pain? □ Yes □ No. Type: _____

Had other premenstrual symptoms? □ Yes □ No. What? _____

Do you think you might be pregnant now? □ Yes □ No □ May be.

Are you menopausal □ Yes □ No Year of Menopause:_____

Are you on hormone replacement therapy? □ Yes □ No

Type: _____ No. of years: _____.

SEXUAL AND CONTRACEPTIVE HISTORY

Have you ever had intercourse? □ Yes □ No.

Age at first intercourse _____ No of Partners in life time: _____

Type of partners: □ Male □ Female □ Both.

Do you have questions/concerns about STDs? _____

Are you using birth control now? □ Yes □ No. Since when? _____.

If yes, what method: _____

Do you desire birth control today? □ Yes □ No. What method? _____.

Have you or your partner ever used birth control? □ Yes □ No.

List any problems with these methods: _____

PREGNANCY HISTORY: Have you ever been pregnant? □ Yes □ No.

Number of pregnancies: ___. Number of miscarriages: ___.

Number of abortions: _____. Number of live births: _____.

FAMILY HISTORY: □ Adopted

List anyone in your family (parents, grandparents, or siblings) who have had:

No	Yes	Unsure	
□	□	□	Breast Cancer_____
□	□	□	Ovarian Cancer_____
□	□	□	Any other type of cancer _____
□	□	□	Diabetes_____
□	□	□	Heart Attack before 50_____
□	□	□	Other Heart Disease_____
□	□	□	Strokes and Blood clots_____
□	□	□	High Cholesterol_____
□	□	□	High Blood pressure_____
□	□	□	Birth Defects/Genetic problems or traits_____

Date: _____ Patient Signature: _____