WOMAN'S CLINIC

NAME _____ CHART# _____ DATE_____
AGE_____

PAST MEDICAL HISTORY

Do you have or have you ever had: (If yes, list treating physician)

Anemia	_____	Heart disease	_____
Blood clots/phlebitis	_____	Liver disease/hepatitis	_____
Breast disease	_____	Lung disease	_____
Bladder/kidney disease	_____	Anxiety/depression	_____
Cancer	_____	Seizures	_____
Diabetes	_____	Thyroid circle one - hyper/hypo	_____
Hypertension	_____	Other	_____

PAST GYNECOLOGIC HISTORY (Please Circle)

Have you ever had:

Abnormal Pap Smear	yes	no	_____
Abnormal periods	yes	no	_____
Bartholin cyst	yes	no	_____
Gynecological cancer	yes	no	_____
Endometriosis	yes	no	_____
Fibroids	yes	no	_____
Ovarian cysts	yes	no	_____
Prolapse	yes	no	_____
Urinary incontinence	yes	no	_____
Infertility	yes	no	_____

Is Intercourse Satisfactory? yes no

Have you ever had (circle): Herpes Condyloma Gonorrhea Chlamydia Syphilis

Other Gynecological problems _____

SCREENING TESTS

When was your last Pap smear? _____

Have you had a mammogram?	yes	no	When _____
Have you had a bone density?	yes	no	When _____
Have you had a screening colonoscopy?	yes	no	When _____

PREVIOUS SURGERY (If yes, list surgeon and year of surgery)

	Date		Date		Date
Appendectomy	_____	Breast		Breast Surgery	_____
Cesarean Section	_____	reduction/implants	_____	Gallbladder	_____
Hysterectomy		D&C	_____	Tubal Ligation	_____
Abdominal	_____	Laparoscopy	_____		
Vaginal	_____				
Ovaries removed	_____				
Tonsillectomy	_____				

Other Surgery _____
_____

OVER

ALLERGIES

Penicillin _____
Sulfa _____
Other _____
_____
_____
_____

FAMILY HISTORY

Who in your family has: (example: mother, father, maternal grandmother/grandfather, paternal grandmother/grandfather)

Breast cancer _____
Colon cancer _____
Diabetes _____
Heart disease _____
High blood pressure _____
Kidney disease _____
Osteoporosis _____
Ovarian cancer _____
Stroke _____
Thyroid disease _____
Gynecologic cancer _____
Other _____

Are parents deceased? Yes / No If yes, list cause of death: _____

LIST ALL MEDICATIONS AND DOSAGE

Medication/Prescribing Physician	Dosage	Medication/Prescribing Physician	Dosage

GENETIC HISTORY

Has anyone in your family had any genetic or inherited disorders? _____

PREGNANCY HISTORY

Pregnancies

Total___ Full term___ Preterm___ Miscarriages___ Tubal Pregnancies___
Living Children___ Abortions___

	Date of Birth	Weeks Pregnant	Weight	Sex	Vaginal/ C-section	Anesthesia	Complications	Child Name	Doctor & Delivery Location
1									
2									
3									
4									
5									

MENSTRUAL HISTORY

Age of onset _____ Frequency every ___ days
Duration of flow _____ days Flow: Light___ Medium___ Heavy___
Cramps: None___ Mild___ Moderate___ Severe___
Date of last period_____ Age of menopause_____
Birth control method _____ Clots _____
Irregular bleeding Yes___ No___ on hormones Yes___ No___

SOCIAL HISTORY

Alcohol use? Yes No Occasionally Frequently
Drug use? Yes No Explain_____
Do you exercise? Yes No How often_____
Marital Status Married Single Divorced Widowed Spouse Name: _____
Do you Smoke? Yes No How much_____ Spouses Occupation_____
Patients Occupation_____ Employer_____ Year Married_____

REASON FOR THIS VISIT

Annual_____ Other _____

Referred by_____