

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 <small>circle one</small> - 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 _____

ALLERGIES

Penicillin _____
 Sulfa _____
 Other _____

FAMILY HISTORY

Who in your family has: (example: mother, father, maternal grandmother/grandfather, paternal grandmother/grandfather)
 Breast cancer _____ Osteoporosis _____
 Colon cancer _____ Ovarian cancer _____
 Diabetes _____ Stroke _____
 Heart disease _____ Thyroid disease _____
 High blood pressure _____ Gynecologic cancer _____
 Kidney disease _____ 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 _____