**GYNECOLOGICAL VISIT**

**The following information is very important to your health. Please take the time to fully complete the information. We are counting on you**

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

**Chief Complaint:** Routine exam? ( ) Yes ( ) No If not routine, please describe problem:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Menses**

Date of last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If postmenopausal, any bleeding in the past year? \_\_\_\_\_\_

Age period started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does your period occur ( ) Regular ( ) Irregular

Duration: \_\_\_\_\_\_ days Usual Flow: ( ) Light ( ) Moderate ( ) Heavy

Pain: ( ) None ( ) Mild ( ) Moderate ( ) Severe

Any medication taken for pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bleeding/spotting between periods? ( ) Yes ( ) No

Current method of birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any Problems? ( ) Yes ( ) No

1. **Surgeries**

Any Gynecological Surgeries? ( ) Yes ( ) No

If yes what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a Hysterectomy: ( ) Total (both ovaries taken) ( ) Partial (ovaries left)

Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Other Medical Care**

Date of Last Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any abnormal pap smears in the past? ( ) Yes ( ) No Type and Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of any Sexually Transmitted Diseases? ( ) Yes ( ) No Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Personal History**

Number of sexual partners in the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_ Lifetime? \_\_\_\_\_\_\_\_\_\_\_

( ) Men ( ) Women ( ) Both

Pregnancy History: ( ) None Number of: Full Term Births\_\_\_\_\_\_ Miscarriages \_\_\_\_\_\_\_\_

Premature Births \_\_\_\_\_ Abortions \_\_\_\_\_\_

If Postmenopausal, are you on hormones? ( ) Yes ( ) No

Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of years \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a Bone Density Test? ( ) Yes ( ) No

If yes, date and results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the following if you currently have or have had any of these issues in the past:

( ) Breast Cancer ( ) Blood Clots

( ) Liver Problems ( ) Migraines

Do you smoke? ( ) Yes ( ) No Packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ( ) None ( ) Moderate ( ) Heavy

Have you ever had a problem with drug abuse? ( ) Yes ( ) No

Exercise regularly? ( ) Yes ( ) No Occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Family History**

Breast Cancer ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovarian Cancer ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cervical Cancer ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uterine Cancer ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colon Cancer ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early (<65) heart disease/heart attack ( ) Yes ( ) No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List**

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| --- | --- | --- |
| **Medication Name** | **Dosage** | **Instruction** |
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor’s office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient/parent/or legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

**Doctor’s Review**

Doctors Signature/ date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_