SOUTHWEST MEDICAL GROUP
MARKET STREET

GYNECOLOGY
PATIENT HISTORY FORM
(Confidential)

Patient Name:_____ Date of Birth:_____

Referred By: □ Self □ Friend □ Dr. _____ □ Other:_____

Reason for Visit: □ GYN Annual Exam □ Abnormal Pap Smear □ Other:_____

MENSTRUAL HISTORY

Date **LAST** menstrual period **began:** _____ / _____/20_____

Age (or grade) when periods **began:** _____ Were they regular at first? □ No □ Yes

Did you have cramps at first? □ No □ Yes Did you miss school? □ No □ Yes

Length of periods as a teenager: _____ days Were periods usually or ever regular? □ No □ Yes

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Frequency of your periods now: □ Monthly □ Every _____ Days Length of periods now: ___ Days

As you got older, were your cramps... □ Better □ Worse □ The Same?

Do you have mid cycle pain/cramping? □ No □ Yes

Do you use: □ Tampons □ Pads □ Both Change every _____ hours with heaviest flow

Do you douche? □ No □ Yes – how often? _____ Do you spot between periods? □ No □ Yes

Do you take medication for cramps now? □ No □ Yes

What kind? □ Ibuprofen □ Birth Control Pills □ Other _____

If you are no longer having periods, age of Menopause: _____ Or age at Hysterectomy: _____

Have you ever had hot-flashes or night sweats? □ No □ Yes

Have you ever taken hormone replacement therapy or estrogen? □ No □ Yes

GYNECOLOGIC HISTORY

Is this your first pelvic examination? □ Yes □ No

Date of last Pap smear: _____ / _____ / _____ by ? _____

Have you ever had an abnormal pap smear? □ No □ Yes – when? _____

How was the abnormal pap evaluated or treated? □ Colposcopy □ LEEP □ Cone Bx □ Cryo

Have you ever had Chlamydia? □ Yes □ No

Have you ever had Gonorrhea? □ Yes □ No

Have you ever had Herpes? □ Yes □ No

Have you ever had Syphilis? □ Yes □ No

Have you ever had: □ Yeast □ Trichomonas □ Gardnerella (BV) □ Genital (Venereal) Warts

Number of lifetime sexual partners (for Medicare risk classification): □ None □ One □ 2-4 □ > 5

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Have you ever had breast problems? ☐ No ☐ Yes

If yes, what problems? _____

Do you do self-breast exams? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY

(If you have never had intercourse, please skip this section)

What are you using for birth control **NOW**? ☐ Nothing ☐ Pill ☐ Condoms ☐ Depo-Provera ☐ Diaphragm ☐ IUD ☐NuvaRing ☐ Implant ☐ Patch ☐ Tubal Sterilization ☐ Partner had Vasectomy

Are you satisfied with your current birth control? ☐ No ☐ Yes

What other methods have you used in the past? ☐ Pills ☐ Condoms ☐ Depo-Provera ☐ Diaphragm ☐ IUD ☐ Implant ☐ Patch ☐ NuvaRing

Have you ever had problems with other methods? ☐ No ☐ Yes

If yes, please describe? _____

Do you have pain with intercourse? ☐ No☐ Yes Do you have bleeding with intercourse? ☐ No ☐Yes

SYSTEM REVIEW

Please check if any of the following **CURRENTLY** apply to you:

Constitutional
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer of any type

Eyes
- ☐ Double vision
- ☐ Vision changes
- ☐ Glaucoma ☐ Cataracts
- ☐ Contacts
- ☐ Glasses

ENT/Mouth
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Mouth sores
- ☐ Hearing loss

Cardiovascular/Vascular
- ☐ Chest pain ☐ Shortness of breath
- ☐ Swelling of legs
- ☐ Palpitations of heart
- ☐ Heart trouble or murmur
- ☐ Stroke
- ☐ High blood pressure

Respiratory
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Cough – chronic
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal
- ☐ Diarrhea, frequent
- ☐ Bloody stools
- ☐ Ulcers or reflux/indigestion
- ☐ Nausea, vomiting
- ☐ Constipation
- ☐ Hemorrhoids

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Urinary
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Incomplete emptying
- ☐ Leaky bladder
- ☐ Previous kidney infections/stones
- ☐ Previous bladder infections

Musculoskeletal
- ☐ Muscle weakness
- ☐ Arthritis/joint pain

Breast
- ☐ Pain in breast
- ☐ Discharge
- ☐ Lumps

Skin
- ☐ Rash
- ☐ Ulcers

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Migraines with Aura
- ☐ Numbness/weakness
- ☐ Trouble walking
- ☐ Seizures/epilepsy

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ History of eating disorder

Endocrine
- ☐ Thyroid disease
- ☐ Diabetes

Hematologic/Lymphatic
- ☐ Bruises, frequent
- ☐ Cuts do not stop bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood clots in legs or lungs
- ☐ Hepatitis/Jaundice
- ☐ Anemia (low blood count)

Patient Signature: _____ Date: _____