

Allergy Label
NKDA

Patient Label

GENERAL HISTORY FORM:

Name: _____

Reason for visit: _____

Birth Control Refill Birth Control Start HPV Vaccine Implanon/IUD Emergency Contraception

Repeat Wart Treatment Infection/STD Check Repeat Pap: Date of last Pap _____

Post abortion check: Date of abortion: _____ LEEP follow-up: date of LEEP _____

Allergies: No Known Allergies Drug Allergies: _____ Seasonal Allergies Other: _____

When I get this allergy I have these symptoms: hives nausea vomiting rash other: _____

List all **medications** or drugs you are taking (including over-the-counter medications/herbal medications/vitamins)birth control):

If you are here for a repeat Pap, repeat wart treatment, LEEP follow-up or post-abortion appointment, you do NOT need to complete any information below.

SEXUAL HISTORY UPDATE: These questions may seem personal but they help us to evaluate your health.
All information is confidential. Please answer only the questions you are comfortable answering.

Do you identify as: Female Male Transgender

Yes No

Have you had sexual intercourse? If yes, age 1st time _____

Are you currently in a sexual relationship?

If yes, do you currently have one partner more than one partner

As far as you know, does your partner have one partner more than one partner

If yes, is your sexual contact: all that apply Vaginal Anal Oral

Have you had more than 1 partner in the past year?

Are your partner(s) all that apply Female Male Transgender

As far as you know, has your current partner been diagnosed with or have symptoms of an STI?

Have you ever been diagnosed with an STI (sexually transmitted infection) in the past? If yes, which

Chlamydia Gonorrhea Herpes Genital Warts/HPV Syphilis Not sure what STI

Are you now or have you ever been afraid in any of your relationships?

Are you now or have you ever been harmed physically or emotionally in any of your relationships?

Unsure Have you received immunizations (shots) against Hepatitis B or Hepatitis A?

To your knowledge, have you or any of your partners used needles to take drugs?

Have you had a blood transfusion or organ transplant prior to 1992

Do you have a history of Hemophilia?

Are you experiencing any unusual vaginal/penile discharge?

If yes, does the discharge: Have an odor Itch Irritating Other

Do you have or have you had any sores or bumps?

Do you have pain with urination?

Do you have to urinate frequently/urgently

Do you have pain or bleeding with intercourse

Have you had a fever at the same time as any of these symptoms?

Do you have any other symptoms? _____

FOR FEMALE PATIENTS, PLEASE COMPLETE BACK SIDE OF THIS FORM

Comments/Other:

To the best of my knowledge, the information on this history form is complete and correct.

Patient signature: _____ Date: ____/____/____

Reviewers Initials: _____

GYN121
042008

GENERAL HISTORY FORM:

THIS SECOND PAGE IS TO BE COMPLETED BY WOMEN ONLY

REVIEW OF SYSTEMS: Do you have or have you had:

YES NO

- Stroke
- Blood clots in legs or lung
- Bleeding condition
- High Blood Pressure
- Heart attack/chest pains/heart disease/valve problems/previous bacterial endocarditis
- Cancer (ovarian, endometrial, cervical)
- Cancer: _____
- Liver tumor or disease
- Hepatitis or mononucleosis
- Kidney/adrenal insufficiency
- Diabetes
- Seizures
- Osteoporosis or broken bones
- Current symptoms of or partner with symptoms of an STI

YES

NO

Uterine abnormalities

Undiagnosed/abnormal vaginal bleeding

Pelvic Tuberculosis

High cholesterol or high lipids

Gall Bladder disease

Breast surgery or disease/cancer

Undiagnosed or unresolved breast mass

Sickle cell disease/trait, Thalassemia

Anorexia

Depression/Anxiety

Genetic condition

Migraine or migraine with aura

IF YES: vision changes start before headache begins

lasts up to one hour resolves before headache starts

Future surgery that requires prolonged bedrest

Postpartum or post abortion infection w/in past 3 months

In the past, I have had allergic reactions to vaccines.

LAST MENSTRUAL PERIOD: ___/___/___

Yes No Was it a normal period?

Yes No Do you have cramps?

Yes No Are your periods regular?

Yes No Do you bleed between your periods?

How many days does your period typically last? _____

LAST PAP SMEAR: ___/___/___

Yes No Was it normal?

Yes No Is there any chance that you could be pregnant today?

Yes No Are you breastfeeding currently?

SOCIAL/SEXUAL HISTORY:

YES NO

Are you over age 35?

Do you smoke? If yes, how much? _____ How long? _____

Have your periods been abnormal or irregular?

Have you had unprotected sex, including not using condoms, since your last period?

Do you think you could be pregnant now?

Are you currently breastfeeding?

FAMILY HISTORY:

YES NO

Has your mother or a sister had a heart attack or stroke before age 65?

Has your father or a brother had a heart attack or stroke before age 55?

Has anyone in your family had osteoporosis?

For Women Only:

By checking the boxes below, I am acknowledging that I have been given and understand this information:

For women 40 years old and greater only:

I understand the importance of and agree to getting an annual breast exam and mammogram, as recommended.

If I do not agree to get these tests, then I will sign a "Release When Test/Service/ Consultation Will Not Be Obtained As Recommended."

I understand the possible risks of using hormonal birth control on undiagnosed breast cancer.

For all women Using or Considering Using the Patch:

If I am using the patch, I understand that there is a slight increase of estrogen absorbed in my body compared to other methods of birth control. I understand that there MIGHT be a slight increase of blood clots if I choose to take this form of birth control.

To the best of my knowledge, the information on this history form is complete and correct.

Patient signature: _____ Date: ___/___/___

Reviewers Initials: _____

