

MEDICAL HISTORY - GYN

Patient Name: _____ **Age:** _____ **Medical Record #:** _____ **Date:** _____

New Patient **Established Patient**

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? Routine GYN Exam Problem Other _____

How do you identify? Female FTM Other _____

No **Yes**
 Are you receiving medical care with another health provider? Reason for visit(s) _____

Are you allergic to any medications, metals, foods, anesthesia or other products? List: _____

Are you currently taking any medications (including herbal remedies and vitamins)? List: _____

FAMILY HISTORY

No **Yes**
 I am adopted; my birth history is unknown.
 Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM) or Grandfather (GF) have any of the following?

No	Yes	Who	No	Yes	Who
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Breast disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack before age 50 _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Blood clots _____	<input type="checkbox"/>	<input type="checkbox"/>	Genetic disorder(s) _____

Circle: Father is living / deceased. Cause of death _____

Mother is living / deceased. Cause of death _____

PERSONAL HISTORY – Have **YOU** been diagnosed or treated for any of the following:

- | | No | Yes |
|-----|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> Genetic condition |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> High cholesterol / triglycerides |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> Heart disease / Murmur / MVP |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> Stroke / Blood clots |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> Anemia |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> Blood clotting disorder |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell anemia / trait |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> Breast problems / Surgery |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> Lung problems / Tuberculosis |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> Kidney / Bladder / Urinary Tract infection or problems |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> Recurrent vaginal infections |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> Pelvic infection / PID |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Pap smear |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> Cervical cryo, LEEP, Laser or Cone biopsy |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> Thyroid disease |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> Liver disease / Hepatitis / Mono |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> Gall bladder disease |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> Past surgery(s) |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> Past hospitalization(s) |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> Vaccination for Hepatitis B |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> Vaccination for Rubella / MMR |

REVIEW OF SYSTEMS – CONTINUED

- | | No | Yes |
|-----------------------------|--------------------------|---|
| Hematological: | | |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> Easily bruised |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> Varicose veins |
| Neurological: | | |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> Headaches (frequent / severe) / Migraine |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> Numbness / Sensory loss |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> Seizures |
| Respiratory / Chest: | | |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> Breast lump / discharge |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> Shortness of breath |
| Eyes: | | |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> Blurred / Double vision (Not corrected by glasses or contacts) |
| Gastrointestinal: | | |
| 36. | <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| 37. | <input type="checkbox"/> | <input type="checkbox"/> Bowel pain / Constipation / Diarrhea |
| 38. | <input type="checkbox"/> | <input type="checkbox"/> Rectal bleeding / Pain |
| Genitourinary: | | |
| 39. | <input type="checkbox"/> | <input type="checkbox"/> Vaginal discharge, itching or burning |
| 40. | <input type="checkbox"/> | <input type="checkbox"/> Frequency or burning with urination |
| 41. | <input type="checkbox"/> | <input type="checkbox"/> Pelvic pain |
| ENT: | | |
| 42. | <input type="checkbox"/> | <input type="checkbox"/> Ulcers / Sores in your mouth |
| Psychological: | | |
| 43. | <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| 44. | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| 45. | <input type="checkbox"/> | <input type="checkbox"/> Would you like a mental health referral today? |
| Skin: | | |
| 46. | <input type="checkbox"/> | <input type="checkbox"/> Rash or itching |

REVIEW OF SYSTEMS

- | | No | Yes |
|------------------------|--------------------------|--|
| Constitutional: | | |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> Generally healthy |
| Cardiovascular: | | |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> Swelling / Fluid retention in hands or feet |

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

HEALTH HABITS / SOCIAL HISTORY

- No Yes**
- Douches
- Self breast exams
- Smokes: _____ cigarettes per day.
- Alcohol intake: _____ drinks per week.
- Drug use: daily / weekly / monthly. Type _____
- Alcohol and/or drugs cause problems in your life?
- Others are concerned with your alcohol / drug habits?
- Afraid of your partner(s) / others?
- Parent(s) or guardian is aware of your visit today?
(Only answer if under age 18.)

SEXUAL HISTORY

- Age at first intercourse: _____
- # of sexual partners in last 30 days: _____
- # of sexual partners in lifetime: _____
- Partner(s) – Check all that apply: Male Female Transgender Intersex
- Kind of sex: (please indicate all that apply):
 Vaginal (Giver / Receiver)
 Anal (Giver / Receiver) Oral (Giver / Receiver)
- Do you have pain or bleeding with sex? No Yes
- Have you ever been forced to have sex? No Yes
- Have you ever exchanged sex for money or something else you wanted? No Yes
- Do you consistently use condoms/dental dams for safer sex? No Yes
- Do you plan children in the future? No Yes Undecided
- Planning a pregnancy within the next year? No Yes Undecided

CONTRACEPTIVE HISTORY

- Current method of birth control: _____
- How long have you used this method? _____
- What other methods of birth control have you used?
- | | | |
|---|---|--|
| <input type="checkbox"/> Pills _____ | <input type="checkbox"/> Diaphragm _____ | <input type="checkbox"/> Rhythm/Natural _____ |
| <input type="checkbox"/> Depo Provera _____ | <input type="checkbox"/> Cervical Cap _____ | <input type="checkbox"/> Withdrawal _____ |
| <input type="checkbox"/> Lunelle _____ | <input type="checkbox"/> Male condoms _____ | <input type="checkbox"/> Abstinence _____ |
| <input type="checkbox"/> Evra Patch _____ | <input type="checkbox"/> Female condoms _____ | <input type="checkbox"/> Tubal sterilization _____ |
| <input type="checkbox"/> Nuva Ring _____ | <input type="checkbox"/> Spermicide _____ | <input type="checkbox"/> Vasectomy _____ |
| <input type="checkbox"/> IUD _____ | <input type="checkbox"/> Norplant _____ | <input type="checkbox"/> Implanon _____ |
- What method, if any, do you want today? _____

I would like the following STI screening today:

- Chlamydia
- Gonorrhea
- HIV
- Syphilis

Patient Signature: _____

MENSTRUAL HISTORY

- Age when period started: _____
- Periods are: Regular Irregular Painful
- Flow is: Light Moderate Heavy
- Periods come every _____ days.
- Bleeding lasts _____ days.
- When was the 1st day of your last period? _____
- No Yes**
- Was your last period normal?
- Do you think you might be pregnant?
- Do you ever miss periods?
- Do you ever have bleeding between periods?

Have you ever had the following?

- No Yes**
- | | |
|---|--------------------------|
| <input type="checkbox"/> <input type="checkbox"/> Chlamydia | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Gonorrhea | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Herpes | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> HPV/warts | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> PID | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> HIV | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Syphilis | Date last treated: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Trichomonas | Date last treated: _____ |
- Currently experiencing itching, burning or unusual discharge?
- Did you douche, use a tampon, have bleeding or sex in the last 3 days?

PREGNANCY HISTORY

- Never Pregnant
- Age at first pregnancy (at time of conception): _____
- | | |
|-----------------------------|---------------|
| # of live births _____ | Date(s) _____ |
| # of C-sections _____ | Date(s) _____ |
| # of premature births _____ | Date(s) _____ |
| # of miscarriages _____ | Date(s) _____ |
| # of still births _____ | Date(s) _____ |
| # of abortions _____ | Date(s) _____ |
| # of ectopics _____ | Date(s) _____ |

I would like information on the following:

- | | |
|---|------------------------------|
| <input type="checkbox"/> Birth Control Method(s) _____ | Given (Staff Initials) _____ |
| <input type="checkbox"/> Emergency Hormonal Contraception _____ | _____ |
| <input type="checkbox"/> Preconception _____ | _____ |
| <input type="checkbox"/> Perimenopause _____ | _____ |
| <input type="checkbox"/> Smoking Cessation _____ | _____ |

Date: _____

Comments:

- STI Risk Assessment done.
- Safer sex and condom use reviewed.
- ECP discussed / Fact Sheet N0051 given.
- HIV pretest counseling done.
- Other _____
- Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: _____

Date: _____

Clinician Signature: _____

Date: _____