

**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"/> | Sickle cell anemia / trait                             |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Breast problems / Surgery                              |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Asthma   |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Lung problems / Tuberculosis                           |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Kidney / Bladder / Urinary Tract infection or problems |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vaginal infections                           |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic infection / PID                                 |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Colposcopy or abnormal pap smear                       |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | Cervical cryo, LEEP, Laser or Cone biopsy              |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes   |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease  |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease / Hepatitis / Mono                       |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder disease                                   |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Past surgery(s)  |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Past hospitalization(s)                                |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for Hepatitis B                            |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for Rubella / MMR                          |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | Vaccination for HPV                                    |

**REVIEW OF SYSTEMS – CONTINUED**

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

**REVIEW OF SYSTEMS**

- |                        | No                       | Yes                      |   |
|------------------------|--------------------------|--------------------------|---|
| <b>Constitutional:</b> |                          |                          |   |
| 26.                    | <input type="checkbox"/> | <input type="checkbox"/> | Generally healthy                           |
| <b>Cardiovascular:</b> |                          |                          |   |
| 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?  
 Pills \_\_\_\_\_  Diaphragm  Rhythm/Natural  
 Depo Provera  Cervical Cap  Withdrawal  
 Lunelle  Male condoms  Abstinence  
 Evra Patch  Female condoms  Tubal sterilization  
 Nuva Ring  Spermicide  Vasectomy  
 IUD \_\_\_\_\_  Norplant  Implanon  
 What method, if any, do you want today? \_\_\_\_\_

**I would like the following STI screening today:**

- Chlamydia
- Gonorrhea
- HIV
- Syphilis

Patient Signature: \_\_\_\_\_

**Comments:**

LNMP: \_\_\_\_\_  
Last UPI: \_\_\_\_\_

Interviewer Signature: \_\_\_\_\_

Clinician 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 1<sup>st</sup> 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**
- Chlamydia Date last treated: \_\_\_\_\_
  - Gonorrhea Date last treated: \_\_\_\_\_
  - Herpes Date last treated: \_\_\_\_\_
  - HPV/warts Date last treated: \_\_\_\_\_
  - PID Date last treated: \_\_\_\_\_
  - HIV Date last treated: \_\_\_\_\_
  - Syphilis Date last treated: \_\_\_\_\_
  - Trichomonas Date last treated: \_\_\_\_\_
  - Currently experiencing itching, burning or unusual discharge?
  - Did you douche, use a tampon, have bleeding or sex in the last 24 hours?

**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:**

- Birth Control Method(s) \_\_\_\_\_ Given (Staff Initials) \_\_\_\_\_
- Emergency Hormonal Contraception \_\_\_\_\_
- Preconception \_\_\_\_\_
- Perimenopause \_\_\_\_\_
- Smoking Cessation \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**Additional History for Women 40 and Over**

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_ Date: \_\_\_\_\_

**Family History**

No Yes Unsure

- Age mother and/or sisters went through menopause  
   Osteoporosis

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**Personal History** Have you ever had or do you have:

No Yes Unsure

- Difficulty holding urine \_\_\_\_\_  
   Hot flashes \_\_\_\_\_  
   Night sweats \_\_\_\_\_  
   Depression/mood swings \_\_\_\_\_  
   Anxiety \_\_\_\_\_  
   Heart palpitations \_\_\_\_\_  
   Sleeplessness \_\_\_\_\_  
   Dryness of the vagina \_\_\_\_\_  
   Change in sexual desire \_\_\_\_\_  
   Pain or difficulty with urination \_\_\_\_\_  
   Change in bowel habits including bloody or tarry stools \_\_\_\_\_  
   Osteoporosis or broken bones after age 35 \_\_\_\_\_  
   Mammogram: Date of last \_\_\_\_\_, result \_\_\_\_\_  
   Other problems \_\_\_\_\_

**Notes**

**Staff Signature:** \_\_\_\_\_