GYNECOLOGIC HEALTH HISTORY QUESTIONNAIRE

Name ______________________ Today's Date ______________________

Race ____________ Marital Status: M S D W Date of Birth ______________ Age _____

Primary Care Physician ______________________

PAST HEALTH HISTORIES

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when started. If you are not certain when an illness started, write down an approximate year.

Illness	(X)	(Year)	Illness	(X)	(Year)	Illness	(X)	(Year)
Glaucoma	___	_____	GI Problems	___	_____	Convulsions/ Seizures	___	_____
Thyroid Problems	___	_____	Diverticulosis	___	_____	Cancer	___	_____
Lung Problems	___	_____	Colitis	___	_____	Anemia	___	_____
Asthma	___	_____	Hepatitis	___	_____	Diabetes	___	_____
High Blood Pressure	___	_____	Liver Problems	___	_____	Osteopenia/ Osteoporosis	___	_____
Heart Attack	___	_____	Breast Problems	___	_____	Other Medical Illness	___	_____
Heart Murmur	___	_____	Kidney or Bladder Disease	___	_____	Depression	___	_____
Rheumatic Fever	___	_____	Phlebitis/Vericose Veins	___	_____	Psychological Disorders	___	_____
Mitral Valve Prolapse	___	_____						
Other Heart Problems ______________								

Please list all times you have been hospitalized, operated on, or seriously injured.

Year	Operation, Illness, Injury	Hospital and City

Family History

Have any blood relatives had any of the following llnesses? If so, indicate relationship.

Illness	Family Members
High blood pressure	
Heart disease	
Stroke	
Cancer, including breast, ovarian, and uterine, other please specify	
Diabetes	
Clotting disorders	
Other	

Current Medications

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________

Are you allergic to any medications?

1. ______________
2. ______________
3. ______________

HABITS

Do you smoke? Yes ____ No ____ Currently packs per day ____ X ____ yrs.
Previously smoked packs per day ____ X ____ yrs.

Alcohol consumption? Yes ____ No ____ Types preferred ____________________

Amount: Daily _____ Weekly __________ Monthly __________;

When was the last time you used street drugs? ____________________: Never __________

Have you ever been treated for drug, alcohol, or psychological disorders? Yes ____ No ____

Specify ____

MENSTRUATION HISTORY

Date of last menstrual period ____________________

Are your periods regular? Yes _____ No _____; approximately every _____ day X _____ days flow.

Are your periods painful? Yes _____ No _____

Are your periods heavy? Yes _____ No _____

What age did your periods begin? ____________________

Do you have any pain between periods? Yes _____ No _____

Have you ever had an abnormal pap smear? Yes _____ No _____; If yes, specify ____________________

When was your last pap smear? ____________________

Have you ever been sexually abused or assaulted? Yes _____ No _____

Do you have any unusual vaginal discharge or burning? Yes _____ No _____

Do you feel tense before your periods? Yes _____ No _____

QUESTIONS REGARDING SEXUAL ACTIVITY

Are you sexually active? Yes _____ No _____ Number of lifetime partners _____

Do you have pain with intercourse? Yes _____ No _____

Have you had more than one partner in the last six months? Yes _____ No _____

Have you had a sexually transmitted disease? Yes _____ No _____

Condylomata (venereal warts) Yes _____ No _____

Chlamydia/Gonorrhea Yes _____ No _____

Genital herpes Yes _____ No _____

Other venereal disease Yes _____ No _____

Do you have any questions or problems concerning sex? Yes _____ No _____

QUESTIONS REGARDING BIRTH CONTROL

What type of birth control do you use? ____________________

If you are taking oral contraceptives, type ____________________

Does your partner have a vasectomy? Yes _____ No _____

Do you have any questions regarding birth control options? Yes _____ No _____

QUESTIONS REGARDING MENOPAUSE IF APPLICABLE

Have your periods become irregular? Yes _____ No _____

Have you gone longer than one year without a period? Yes _____ No _____

Do you have hot flashes? Yes _____ No _____

Have you ever taken estrogen replacement therapy? Yes _____ No _____

Are you interested in information regarding hormone replacement therapy? Yes _____ No _____

QUESTIONS REGARDING BREASTS

Do you know how to do a self-breast exam? Yes _____ No _____

Do you examine your breasts monthly? Yes _____ No _____

Have you ever been diagnosed with fibrocystic breast disease? Yes _____ No _____

Have you ever had a breast biopsy? Yes _____ No _____

Does anyone in your family have breast cancer? Yes _____ No _____

Do you have any breast discharge? Yes _____ No _____

Do you have breast tenderness? Yes _____ No _____

Do you have any breast lumps? Yes _____ No _____

Last Mammogram _______

Bone Mineral Density Results _______________

Colonoscopy _______________

PREGNANCY HISTORY IF APPLICABLE

Have you ever been pregnant? Yes _____ No _____

Have you ever had a miscarriage? Yes _____ No _____ Date: _______________

Have you ever had an abortion? Yes _____ No _____ Date: _______________

Any complications? ____________________

Living children _______________; Premature births _______________; Stillbirth _______________

Any complications with pregnancy? Yes _____ No _____; Date _______________

DELIVERIES

NO	BORN MONTH/YEAR	WEIGHT AT BIRTH	SEX	LENGTH OF PREGNANCY	DELIVERY TYPE	COMPLICATIONS DESCRIBE - IF ANY
1						
2						
3						
4						