My WOMEN'S CENTER
Gyn. Health. Beauty. Joy.

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL!!!

Name: _____ Date: _____ Primary Care Dr.: _____
Why are you seeking medical attention? _____

_____

How did you hear about us? _____
Allergies: _____

_____

Smoking - Cig/day_____ # of years _____
Alcohol _____drinks/week

Birth Control Method:

_____

	Normal	Abnormal
Date of: Last PAP _____	☐	☐
Mammogram _____	☐	☐
Colonoscopy _____	☐	☐
DEXA (Bone Density) _____	☐	☐
Cholesterol _____	☐	☐
Cervical Cancer Vaccination _____	☐	☐

Have you ever been or are you currently involved in an abusive relationship? YES ☐ NO ☐

PERSONAL HISTORY - Have you ever had:

☐ Hepatitis ☐ Broken Bone ☐ Chlamydia/Gonorrhea ☐ Blood Transfusion
☐ Herpes Oral ☐ Rheumatic Fever ☐ Tubal Infection ☐ AIDS/HIV
☐ Herpes Genital ☐ Genital Warts ☐ Bladder or Kidney infection ☐ Other _____

ILLNESSES - Have you ever had:

☐ Anemia ☐ Hernia ☐ Jaundice ☐ Back trouble ☐ Osteoporosis/Osteotenia
☐ Kidney stones ☐ Stroke ☐ Migraine ☐ Diabetes ☐ Gall Bladder troubles
☐ Arthritis ☐ Seizure ☐ Heart problem ☐ Colitis/Diverticulosis ☐ Bleeding disorder
☐ High blood pressure ☐ Asthma ☐ Hemorrhoids ☐ Ulcer/Reflux ☐ Depression/Anxiety
☐ Cancer/Where _____ ☐ Blood clots/Where _____ ☐ Abnormal pap smear
☐ Other, explain: _____ ☐ Thyroid disease

Have you ever been hospitalized for any illness? Yes ☐ No ☐
Year:_____ Diagnosis: _____

Do you take antibiotics when you have your teeth cleaned? Yes ☐ No ☐

SURGERY - Have you had an operation on any of the following:

	Year		*Year*		*Year*
☐ Appendix	_____	☐ Hernia	_____	☐ Ovary	_____
☐ Gall Bladder	_____	☐ Spine/Back	_____	☐ Tubes	_____
☐ Hemorrhoids	_____	☐ Tonsils	_____	☐ Uterus	_____
☐ Thyroid	_____	☐ Heart	_____	☐ Vagina or bladder	_____
☐ Tumor/Location	_____	☐ Breast	_____	☐ Laparoscopy	_____
_____		☐ Endometrial Ablation	_____	☐ Cesarean Section	_____

☐ Other, explain: _____

Have you ever been advised to have any surgical operation, which has not been done? Yes ☐ No ☐

MENSTRUAL HISTORY:

Age of first period? _____ Menstrual flow usually lasts a total of _____ days.
Have you missed periods without being pregnant? Yes ☐ No ☐

MENSTRUAL HISTORY - Continued

When NOT on birth control pills, are your periods: regular ☐ somewhat regular ☐ or completely irregular ☐
How many days between periods? _____
Menstrual flow is usually: scant ☐ moderate ☐ heavy ☐ excessive with clots ☐
Are your periods usually painful? Yes ☐ No ☐
If painful, is it mild ☐, moderate ☐, severe ☐, incapacitating ☐?
Do you ever have bleeding or spotting between periods or following intercourse? Yes ☐ No ☐
Do you have problems with infertility? Yes ☐ No ☐
If you are not menstruating, what age did it stop? Any bleeding or spotting since? Yes ☐ No ☐
Do you have any abdominal or pelvic pain when not on your period?
Do you have any pain with sexual intercourse? Yes ☐ No ☐
Do you have any other complaint, concern or question regarding sex? Yes ☐ No ☐
Do you have any vaginal or vulva irritation, heavy discharge or dryness? Yes ☐ No ☐
Do you frequently have loss of urine with sneezing and coughing? Yes ☐ No ☐
Do you have frequent urination, dribbling of urine or bedwetting? Yes ☐ No ☐
Do you have a protrusion or bulging sensation from your vagina? Yes ☐ No ☐

OBSTETRIC HISTORY

How many pregnancies?_____ How many Cesarean sections?_____
How many babies born alive?_____ Still births?_____ How many miscarriages ? _____
How many prematures (less than 5 ½ lbs.) born alive?_____ What is the largest baby's weight? _____
Any serious complications with any pregnancy? If yes, explain: _____

How many living children do you have?_____ Year 1st child was born?_____ Year last child was born? _____

MEDICATIONS - Please list your current medications, dosage & frequency *(including vitamins and supplements)*

FAMILY HISTORY

	Age	*Health*	*Age at Death*	*If Deceased, Cause*	*Has any relative had:*	✓	*If so, who?*
Father					Diabetes		
Mother					Heart Disease		
Brother or Sister					High Blood Pressure		
2.					High Cholesterol		
3.					Blood Clots		
4.					Endometriosis		
5.					Parent with hip fracture		
Son or Daughter					Cancer		
					Relative - Cancer Type		
2.							
3.							
4.							
5.							