GYN Patient History Form

NAME _____ Date ____/____/____

Date of Birth _____

A. DO YOU NOW:

□ Have vaginal itching?
□ Have abnormal vaginal discharge?
□ Smoke? If yes, number of cigarettes per day

B. MENSTRUAL HISTORY

1. Age periods began?

2. Length of period? ____ days # of days between periods? ____

3. Are your periods usually regular? □ Yes □ No

4. Last period started on _____

It seemed □ Normal □ Not normal

5. Do you experience, before or after periods, □ Cramps? □ Bloating? □ Bowel problems? □ Emotional changes? □ Acne?

6. Do you have vaginal bleeding after sex? □ Yes □ No □ Not applicable

7. Do you have vaginal bleeding between menstrual periods? □ Yes □ No

8. Last pelvic exam

9. Last PAP smear _____
History of abnormal PAP? □ Yes □ No If yes, when?

C. CONTRACEPTIVE HISTORY

Current birth control method(s)?_____ How long used?
Any problems with this method? □ Yes □ No
If yes, what?

What method do you want to use now?

Are you planning on a pregnancy within the NEXT year? □ Yes □ No

If not, what would you do if you became pregnant within the NEXT year?

Which of the following methods have you used in the past?

METHOD	COMMENT / PROBLEM
□ Abstinence □ Birth Control Pill □ The Patch □ The Ring □ Depo-Provera (The Shot) □ Condoms □ Diaphragm □ FemCap □ Sponge □ Spermacide □ Rhythm □ Withdrawal □ Other (IUD, implant, tubal)	

D. SOCIAL HISTORY	COMMENT
Emotional problems □ Yes □ No Relationship problems □ Yes □ No Have you ever been or are you now physically abused? □ Yes □ No Problems in: Living arrangements □ Yes □ No School Problems □ Yes □ No Are you afraid of your partner or family member? Who helps and supports you with your problems?	

E. STI / HIV RISKS

Number of sex partners in your life?____ MEN ____ WOMEN
How many sex partners have you had during the past year?
Does your partner have sex with □ men □ women □ both?
Do you have (check all that apply) □ vaginal □ oral □ anal sex?
Have you had an STI? (sexually transmitted infection) □ Yes □No
Have you ever used street drugs? □ Yes □ No
If yes, when?

Have you received blood or blood products prior to 1978?
□ Yes □ No

Were any of your partners:
□ a street drug user □ a hemophiliac
□ infected with HIV / AIDS
□ MSM (men having sex with men)

Have you ever shared needles? Examples: injecting drugs, tattooing, piercing? □ Yes □ No

F. HAVE YOU EVER HAD SIGNIFICANT TROUBLE WITH:

□ Acne	□ High blood pressure
□ Migraine Headaches	□ Dizziness
□ Anemia	□ Depression
□ Stroke	□ Heart disease
□ Breast lump	□ Liver disease
□ Thyroid Disorder	□ Herpes
□ Cancer / leukemia	□ Blood Clots
□ Tumors/ cysts of ovaries	□ Other

G. Family History

Has any one of your immediate family members ever had:
(please check and indicate relationship):

□ Blood disorder	□ High blood pressure
□ Diabetes	□ Stroke
□ Cancer	□ Blood Clots
□ Heart disease	□ Other

H. PREGNANCY HISTORY

□ never pregnant □ delivered □ abortion / miscarriage

STAFF COMMENTS (do not write anything in this space)

Exercise:

Nutrition:

To the best of my knowledge, the information I have provided is correct and complete

Patient Signature Date

Staff Signature Date