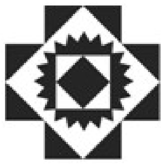

SOUTHWEST MEDICAL GROUP
WOMEN'S AND FAMILY HEALTH
FAMILY MEDICINE
OBSTETRICS
GYNECOLOGY
An Affiliate of Southwest Health System

GYNECOLOGY
PATIENT HISTORY FORM
(Confidential)

Patient Name:____Date of Birth:__________________________

Referred By: ☐ Self ☐ Friend ☐ Dr.________________________☐ Other:______________________________

Reason for Visit: ☐ GYN Annual Exam ☐ Abnormal Pap Smear ☐ Other:_____________________________

MENSTRUAL HISTORY

Date **LAST** menstrual period **began:**__________/_________/20______

Age (or grade) when periods **began:**____________ Were they regular at first? ☐ No ☐ Yes

Did you have cramps at first? ☐ No ☐ Yes Did you miss school? ☐ No ☐ Yes

Length of periods as a teenager:_________days Were periods usually or ever regular? ☐ No ☐ Yes

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Frequency of your periods now: ☐ Monthly ☐ Every______Days Length of periods now:____Days

As you got older, were your cramps... ☐ Better ☐ Worse ☐ The Same?

Do you have mid cycle pain/cramping? ☐ No ☐ Yes

Do you use: ☐ Tampons ☐ Pads ☐ Both Change every _______hours with heaviest flow

Do you douche? ☐ No ☐ Yes – how often? _________ Do you spot between periods? ☐ No ☐ Yes

Do you take medication for cramps now? ☐ No ☐ Yes

What kind? ☐ Ibuprofen ☐ Birth Control Pills ☐ Other ________________

If you are no longer having periods, age of Menopause:__________Or age at Hysterectomy: ______

Have you ever had hot-flashes or night sweats? ☐ No ☐ Yes

Have you ever taken hormone replacement therapy or estrogen? ☐ No ☐ Yes

GYNECOLOGIC HISTORY

Is this your first pelvic examination? ☐ Yes ☐ No

Date of last Pap smear: _____/_____/_____by ? ______________

Have you ever had an abnormal pap smear? ☐ No ☐ Yes – when? __________________

How was the abnormal pap evaluated or treated? ☐ Colposcopy ☐ LEEP ☐ Cone Bx ☐ Cryo

Have you ever had Chlamydia? ☐ Yes ☐ No

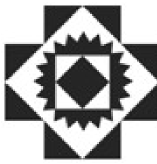
Have you ever had Gonorrhea? ☐ Yes ☐ No

Have you ever had Herpes? ☐ Yes ☐ No

Have you ever had Syphilis? ☐ Yes ☐ No

Have you ever had: ☐ Yeast ☐ Trichomonas ☐ Gardnerella (BV) ☐ Genital (Venereal) Warts

Number of lifetime sexual partners (for Medicare risk classification): ☐ None ☐ One ☐ 2-4 ☐ ≥5



Have you ever had breast problems? ☐ No ☐ Yes

If yes, what problems? ______________________________

Do you do self-breast exams? ☐ Yes ☐ No

CONTRACEPTIVE HISTORY

(If you have never had intercourse, please skip this section)

What are you using for birth control **NOW**? ☐ Nothing ☐ Pill ☐ Condoms ☐ Depo-Provera ☐ Diaphragm ☐ IUD ☐NuvaRing ☐ Implant ☐ Patch ☐ Tubal Sterilization ☐ Partner had Vasectomy

Are you satisfied with your current birth control? ☐ No ☐ Yes

What other methods have you used in the past? ☐ Pills ☐ Condoms ☐ Depo-Provera ☐ Diaphragm ☐ IUD ☐ Implant ☐ Patch ☐ NuvaRing

Have you ever had problems with other methods? ☐ No ☐ Yes

If yes, please describe? ______________________________

Do you have pain with intercourse? ☐ No☐ Yes Do you have bleeding with intercourse? ☐ No ☐Yes

SYSTEM REVIEW

Please check if any of the following **CURRENTLY** apply to you:

Constitutional
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer of any type

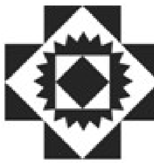
Eyes
- ☐ Double vision
- ☐ Vision changes
- ☐ Glaucoma ☐ Cataracts
- ☐ Contacts
- ☐ Glasses

ENT/Mouth
- ☐ Ear aches
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Mouth sores
- ☐ Hearing loss

Cardiovascular/Vascular
- ☐ Chest pain ☐ Shortness of breath
- ☐ Swelling of legs
- ☐ Palpitations of heart
- ☐ Heart trouble or murmur
- ☐ Stroke
- ☐ High blood pressure

Respiratory
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Cough – chronic
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal
- ☐ Diarrhea, frequent
- ☐ Bloody stools
- ☐ Ulcers or reflux/indigestion
- ☐ Nausea, vomiting
- ☐ Constipation
- ☐ Hemorrhoids



Urinary
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Incomplete emptying
- ☐ Leaky bladder
- ☐ Previous kidney infections/stones
- ☐ Previous bladder infections

Musculoskeletal
- ☐ Muscle weakness
- ☐ Arthritis/joint pain

Breast
- ☐ Pain in breast
- ☐ Discharge
- ☐ Lumps

Skin
- ☐ Rash
- ☐ Ulcers

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Migraines with Aura
- ☐ Numbness/weakness
- ☐ Trouble walking
- ☐ Seizures/epilepsy

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ History of eating disorder

Endocrine
- ☐ Thyroid disease
- ☐ Diabetes

Hematologic/Lymphatic
- ☐ Bruises, frequent
- ☐ Cuts do not stop bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood clots in legs or lungs
- ☐ Hepatitis/Jaundice
- ☐ Anemia (low blood count)

Patient Signature:____ Date: __________________