GYNECOLOGIC HEALTH HISTORY

Date:_____

Patient Name:_____ **Age:**_____

Name you would like us to use:_____ Referred by:_____

Gender Identification (preferred personal pronouns): ☐ She/Her ☐ He/Him ☐ They/Them

Why have you come to the office today?_____

Is this a new problem? ☐ Yes ☐ No

If you are here for an annual exam, is this a: ☐ Primary Care Visit (full physical) ☐ Gynecology Only

Please describe your problem, including where it is, how severe it is, and how long it has lasted.

_____

_____

_____

If you are uncomfortable answering any questions, leave them blank, you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

Last normal menstrual period (first day):_____ Age periods began:_____

Length of periods (number of days of bleeding):_____ Number of days between periods (from start to start):_____

Any recent changes in periods? ☐ Yes ☐ No If Yes, Explain:_____

Are you currently sexually active? ☐ Yes ☐ No

Have you ever had sex? ☐ Yes ☐ No

Number of sexual partners in the last 5 years?_____ Present method of birth control:_____

Sexual partners are: ☐ Men ☐ Women ☐ Both

Have you ever used an intrauterine device (IUD)? ☐ Yes ☐ No If yes, for how long?_____

Have you ever used any birth control pills? ☐ Yes ☐ No If yes, for how long?_____

Any difficulty getting pregnant? ☐ Yes ☐ No

When was your last pap test?_____ What was the result?_____

Have you ever had an abnormal pap test? ☐ Yes ☐ No If Yes, when?_____ How treated?_____

When was your last mammogram?_____ What was the result?_____

Last colon screening?_____ Result?_____

Last bone density?_____ Result?_____

Do you do regular self-breast examinations? ☐ Yes ☐ No If Yes, how often?_____

Have you had the Cervical Cancer/HPV vaccine?

☐ Yes ☐ No If Yes, when?_____

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies (Total)		Abortions		Miscarriages	
Premature Births (<37 weeks)		Live Births		Living Children	

No.	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of delivery (vaginal, Cesarean, etc.)	Complications?
1.						
2.						
3.						
4.						
5.						
6.						

Medication Allergies:_____

Livingston HealthCare
Billings Clinic Affiliate

Patient Label Here

CURRENT MEDICATIONS

*****Including supplements, vitamins, herbs, nonprescription medications*****

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

Mother: □ Living □ Deceased – Cause: Age:	**Father:** □ Living □ Deceased-Cause: Age:
Siblings: Number Living: Number Deceased: Causes(s)/Ages(s):	
Children: Number Living: Number Deceased: Causes(s)/Ages(s):	

Yes	No	Illness	Which relative(s)	Yes	No	Illness	Which relative(s)
□	□	Diabetes		□	□	Tuberculosis	
□	□	Stroke		□	□	Birth defects	
□	□	Heart disease		□	□	Drinking or drug problems	
□	□	Blood clots in lungs or legs		□	□	Breast cancer	
□	□	High blood pressure		□	□	Colon cancer	
□	□	High cholesterol		□	□	Ovarian cancer	
□	□	Osteoporosis		□	□	Uterine cancer	
□	□	Hepatitis		□	□	Mental illness/depression	
□	□	Thyroid		□	□	Alzheimer's disease	
				□	□	Other	

SOCIAL HISTORY

Yes	No	
□	□	Ever smoked?
□	□	Current smoking: Packs per day?_____ Years?____
□	□	Alcohol: Drinks per day:_____ Drinks per week:____
□	□	Recreational drug use?
□	□	Seat belt use?
□	□	Regular exercise: How often?_____
□	□	Caffeine? How much?_____
□	□	Dairy product intake/calcium supplements?_____
□	□	Have you ever been sexually abused, threatened or hurt by anyone?
□	□	In the last 12 months?

OPERATIONS/HOSPITALIZATIONS

Date	Reason	Date	Reason

PERSONAL PAST HISTORY

Yes	No	Major Illnesses	Date
□	□	Asthma	
□	□	Pneumonia/Lung disease	
□	□	Kidney infections/Stones	
□	□	Alcohol/Drug addiction or abuse	
□	□	Breast biopsies or aspirations	
□	□	Osteoporosis/osteopenia	
□	□	Heart attack/Problems	
□	□	Diabetes	
□	□	High blood pressure	
□	□	Stroke	
□	□	Rheumatic Fever	
□	□	Blood clots in lungs or legs	
□	□	Eating disorders	
□	□	Collagen vascular disease (LUPUS)	
□	□	Chickenpox	
□	□	Cancer	
□	□	Reflux/Hiatal hernia/Ulcers	
□	□	OTHER	

Yes	No	Major Illnesses	Date
□	□	Depression/Anxiety	
□	□	Anemia	
□	□	Blood transfusions	
□	□	Seizures/Convulsions/Epilepsy	
□	□	Bowel problems	
□	□	Glaucoma or Cataracts	
□	□	Eczema/Psoriasis	
□	□	Arthritis/joint pain/back problems	
□	□	Hepatitis/yellow jaundice/liver disease	
□	□	Thyroid disease	
□	□	Headaches	
□	□	Endometriosis	
□	□	Herpes	
□	□	PID	
□	□	Chlamydia	
□	□	Gonorrhea	
□	□	Venereal warts/HPV	
□	□	DES Exposure	

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you.

- □ Weight Loss (unintentional)
- □ Weight Gain
- □ Change in height
- □ Frequent moods of anxiety and/or depression

Breasts

- □ Pain in breast
- □ Nipple discharge
- □ Lumps?

Endocrine

- □ Hair loss
- □ Heat/cold intolerance
- □ Abnormal thirst
- □ Change in moles

Genitourinary

- □ Involuntary loss of gas or stool
- □ Pain with urination
- □ Strong urgency to urinate
- □ Frequent urination
- □ Incomplete emptying of bladder
- □ Involuntary/unintended urine loss
- □ Abnormal bleeding/periods
- □ Missed periods
- □ Painful periods
- □ Premenstrual syndrome (PMS)
- □ Painful intercourse
- □ Abnormal vaginal discharge/itching

If you are over 40 or have questions about menopause, do you have:

□ Frequently	□ Rarely	□ No	Night sweats
□ Frequently	□ Rarely	□ No	Hot flashes
□ Frequently	□ Rarely	□ No	Pain with intercourse
□ Frequently	□ Rarely	□ No	Vaginal dryness
□ Frequently	□ Rarely	□ No	Sleeping problems
□ Frequently	□ Rarely	□ No	Difficulty concentrating or memory loss
□ Frequently	□ Rarely	□ No	Mood swings
□ Frequently	□ Rarely	□ No	Migraines
□ Frequently	□ Rarely	□ No	Depression □ Cyclic
□ Frequently	□ Rarely	□ No	Anxiety □ Cyclic
□ Frequently	□ Rarely	□ No	Decrease in sexual desire
□ Frequently	□ Rarely	□ No	Decrease in energy level

Date:_____ **Signature:**_____