DR N GYN

RM:
WWE:_____
NP-WWE:_____

_____

Ht:_____
Wt:_____
BMI:_____
BP:_____
P:_____R:_____

CONFIDENTIAL HEALTH HISTORY

TODAY'S DATE:_____

PATIENT NAME:_____DOB:_____AGE:_____

Are there any health concerns or problems you wish to discuss with your doctor today?_____

_____

WOULD YOU LIKE A CHAPERONE PRESENT DURING YOUR EXAM? _____

DO YOU ALLOW THE DOCTOR TO VIEW YOUR PRESCIPTION HISTORY IF NEEDED?_____

PERSONAL PAST MEDICAL HISTORY

Please check any **diagnosed** medical conditions or problems.

___NONE ___Anemia ___Asthma/Lung Problems ___Bladder Problems

___Blood Clotting Disorder ___Cancer (type:_____) ___Depression ___Diabetes (type:_____)

___Eating Disorder ___Eye Problem ___Fracture (if within the last 5 yrs) ___Gallbladder/Liver Problem

___Heart Disease ___High Blood Pressure ___High Cholesterol ___Kidney Problem

___Major Infections (TB, Hepatitis, HIV, etc) ___Migraines/Severe Headaches ___Osteoporosis

___Other Psychiatric Problems ___Seizures ___Stomach or Bowel Problem ___Stroke

___Thyroid Disorder ___OTHER:_____

FAMILY MEDICAL HISTORY

Please specify which family member and which side of your family (maternal or paternal)

	Relation		Relation
Anesthetic Reaction		Osteoporosis	
Breast Cancer		Ovarian Cancer	
Colon Cancer		Thyroid disorder	
Diabetes (specify type)		Uterine Cancer	
Heart Disease		Other (specify)	
Inherited Disease(s)			

SCREENING STUDIES

Please indicate dates to the best of your ability.

	Date/Provider		Date/Provider
PAP Smear:		Mammogram:	
Abnormal pap smear:		Colonoscopy:	
Bone Density:		Cholesterol Panel:	
Eye Exam:		Gardasil Series:	

PAST SURGICAL HISTORY

Please list ALL surgeries (e.g. C-sections, hysterectomy, abortion, hip replacement, etc.)

___NO SURGICAL HISTORY

Surgery or Procedure	Date	Performed by	Reason/outcome

MEDICATIONS

*Please include **ALL** over-the-counter, prescription, alternative and herbal products.*

___NO MEDICATIONS

Medication name and dose	Instructions	Prescribed by

ALLERGIES

*Please list allergies to all products, **including** medications, food and environmental allergens.*

___NO KNOWN ALLERGIES

Medication name	Reaction	Food/Environmental	Reaction

GYNECOLOGIC HISTORY

Last Menstrual Period (*first day*):_____ Periods occur : Every_____days
(ex. 28 days)

Period length (flow days):_____days

Average flow: ___Light ___Medium ___Heavy

INFECTION HISTORY

___NO KNOWN INFECTIONS

	Dates		Dates
___Chlamydia	_____	___Herpes	_____
___Gonorrhea	_____	___Other	_____

OBSTERTRIC HISTORY

Total Pregnancies:_____Premature:_____Abortions:_____Miscarriages:_____Living:_____

Child(rens) names and ages:_____

_____

SOCIAL HISTORY

___Single ___Married ___In a Relationship ___Divorced ___Separated ___Widowed

Are you sexually active: ___Yes ___No With: ___Male ___Female ___Both

Number of sexual partners in the last: 1 year_____ 3 years:_____ Other:_____

Birth Control Method (Please circle) Pill, IUD-type_____, Condom, Withdraw, Nexplanon, Sterilization, Spermicides, Natural Family Planning, None

Do you feel safe in your current relationship?_____

Occupation:_____

Education Level: ___None ___Grade School ___High School ___College

Alcohol: ___None ___Drinks per week

Tobacco: ___Never ___Current ___Former (age you started____ age you quit____)
___Everyday - how much_____ Occasionally - how often_____

Caffeine: ___None ___Cups per day coffee_____ tea_____ soda/pop_____

Recreational Drugs:___None ___Prescription Medication ___Other(s):_____

Exercise: ___None ___Active but no formal exercise ___Once weekly or less ___1-3 times weekly
___4 or more times weekly

Review of Symptoms (Please check all that apply, Past or Present)

General	NO	YES
Weight Gain/loss		
Generally healthy		
Change in Strength		
Are you able to Exercise?		
Head		
Headaches		
Vertigo		
Head injuries		
Eyes		
Change in vision		
Ears		
Change in hearing		
Nose		
Nose bleeds		
Abnormal discharge		
Mouth		
Dental difficulties		
Gum bleeding		
Neck		
Stiffness, Tenderness, Pain		
Breast		
Lumps		
Tenderness		
Swelling		
Nipple discharge		
Chest		
Shortness of breath		
Wheezing		
Coughing up blood		
Cough		
Psychiatric		
Depressive symptoms		
Change in sleep habits		

Heart	NO	YES
Chest Pain		
Palpitations		
Fainting		
Abdomen		
Change in appetite		
Difficulty swallowing		
Abdominal pain		
Change in bowels		
Vomiting		
Genitourinary		
Urinary Leaking		
Urinary urgency		
Painful urination		
GYN		
Menopausal symptoms		
Sexuality Concerns		
Change in periods		
Painful Cramping		
Vaginal discharge		
Pelvic Pain		
Painful sex		
Vaginal dryness		
Musculoskeletal		
Pain in muscles/joints		
Limitation in range of motion		
Numbness		
Neurologic		
Weakness		
Tremors		
Seizures		
Loss of coordination		
Change in thought content		