**NAME:__________________DATE:________ BIRTHDATE:___**

ALLERGIES TO MEDICATIONS (include type of reaction):____________________

____________________________________________________________

MEDICATIONS prescription, over-the-counter, herbs (include dosage and frequency):

____________________________________________________________

____________________________________________________________

____________________________________________________________

SURGERIES and BIOPSIES (include year): ______________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

| YOUR medical history: | FAMILY medical history/ Affected relative: |
|---|---|
| ☐ high blood pressure | ☐ ________________ |
| ☐ diabetes | ☐ ________________ |
| ☐ heart disease | ☐ ________________ |
| ☐ stroke | ☐ ________________ |
| ☐ bleeding disorder; abnormal blood clots | ☐ ________________ |
| ☐ endometriosis | ☐ ________________ |
| ☐ asthma | ☐ ________________ |
| ☐ seizures | ☐ ________________ |
| ☐ lupus or other joint disease | ☐ ________________ |
| ☐ depression | ☐ ________________ |
| ☐ anxiety | ☐ ________________ |
| ☐ bipolar disorder | ☐ ________________ |
| ☐ anorexia or bulimia | ☐ ________________ |
| ☐ irritable bowel syndrome | ☐ ________________ |
| ☐ Crohn's disease or ulcerative colitis | ☐ ________________ |
| ☐ breast cancer | ☐ ________________ |
| ☐ cancer of the uterus, cervix or ovary | ☐ ________________ |
| ☐ colon cancer | ☐ ________________ |
| ☐ thyroid disease | ☐ ________________ |
| ☐ other ______________ | ☐ ________________ |

GYNECOLOGIC history:

Age of first period:_____ Age of final period (if applicable):_____

Frequency of periods: every _____ days Duration of flow:_____ days

Date of last Pap smear:_____ Date(s) of any abnormal Pap smears:___________

Treatment for abnormal Pap smears (year):_____ ☐ cryotherapy ☐ LEEP ☐ cone biopsy ☐ laser ablation

Treatment for (year):_____ ☐ gonorrhea ☐ chlamydia ☐ PID ☐ herpes ☐ warts/HPV

Method of birth control:______________________

SOCIAL history (please list type, quantity per day, duration of use):

tobacco:____________________________________

alcohol:____________________________________

drugs:____________________________________

Occupation:______________ Marital status:_____ Exercise routine:______________

**FOR OFFICE USE ONLY**

## GYN PROBLEM LIST

GYN SURGERIES:

| 1. |
|---|
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

| PROBLEM | PLAN |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

OBSTETRICAL HISTORY
G____P____A____

| YEAR | SEX | WEIGHT | WKS GEST | DELIVERY TYPE | COMPLICATIONS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |