NAME____DATE____________________

To enable us to serve you better, please provide us with your personal medical history. Include family medical history only when your mother, father, sister(s), or brother (s) are affected. Please be as accurate as possible. If you are uncertain about an item, place a question mark or leave the area blank. Any information you disclose will be considered strictly confidential. Thank you for your assistance.

Areas of Concern	You	Family	Details
Anus/Rectum			
Birth Defects			
Blood disorders			
Blood transfusions you received. Please list dates if known.			
Blood Vessels			
Bones/Joints			
Brain/Nervous System			
Breast			
Cancer			
Diabetes			
Ears			
Eyes			
Heart/Blood Pressure			
Kidney/Bladder			
Liver/Gallbladder			
Lungs			
Nose/Sinuses/Throat			
Psychologic Disorder			
Skin			
Stomach/Intestines			
Surgery (Non-GYN)			
Yours Only. Please List Dates			
Thyroid Disease			
Veins/Phlebitis			
Other			

Drug Allergies			
Tobacco Use		Alcohol Use	
Other			

Medications (Please Leave this Blank; Office Staff Will Complete)

Miscarriages, Tubal Pregnancies, and Abortions (any pregnancy loss before 20 weeks)

#	Year	Weeks Pregnant	Miscarriage	Tubal Preg	Abortion	Comments/Complications
1						
2						
3						
4						
5						
6						

Vaginal Deliveries and C-Sections (Any Pregnancy Delivered After 20 Weeks)

#	Year of Delivery	Pre Term	Full Term	Over Due	Length Of Labor	Type of Delivery	Weight Of Baby	Sex of Baby	Name of Baby	Comments/Complications
1										
2										
3										
4										
5										
6										
7										
8										

Gynecologic History - Please Circle Answers or Fill In Space

Did your mother take DES while she was pregnant with you?	Yes	No	Unsure
How old were you when you had your first period?	10 or younger	11-15	16 0r Older
Usual Cycle Length	25 days or less	26-35	Longer than 35 days
How predictable is the timing of your periods?	Very predictable	Occasionally predictable	Never can tell when my period will start
Usual period length	1-4 days	5-7 days	8+ days
Typical Flow	Light	Moderate	Heavy
Cramping	None or Mild	Moderate	Severe
PMS	None or Mild	Moderate	Severe
Methods of contraception used during your life	Pills / Patch / Ring	DepoProvera Diaphragm	IUD Rhythm
Methods of contraception you currently use	Pills / Patch / Ring	DepoProvera Diaphragm	IUD Rhythm
Date of Last Pap		Result	
Abnormal Paps in past		Treatment	
Pelvic Infections			
Pelvic Surgeries-Please list dates			
Infertility treatment /Difficulties getting pregnant			
Sexual difficulties/pain with sex			
Other gynecologic conditions you have experienced	Herpes Genital Warts	Gonorrhea Chlamydia Fibroids	Ovarian Cysts Endometriosis Other
Gynecologic problems in your family			