

# WOMAN TO WOMAN, P.C.

## Gynecology - Initial History

PATIENT NAME: \_\_\_\_\_

PAST MEDICAL & FAMILY HISTORY - Please Check (✓) If You Or Any Blood Relative (Fam) Had Any Of The Following Conditions

	You	Fam		You	Fam
1. Wt. Loss-Gain	<input type="checkbox"/>	_____	13. Urinary Infections	<input type="checkbox"/>	_____
2. Headaches/Migraine	<input type="checkbox"/>	_____	14. Blood Transfusions	<input type="checkbox"/>	_____
3. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Anemia/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Varicose Veins/Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	17. Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
4. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	18. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
5. Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	19. Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
6. Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	20. Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
7. Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	21. Cancer (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
8. Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	(type _____)	<input type="checkbox"/>	<input type="checkbox"/>
9. H. Hernia/Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	22. Epilepsy/Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
10. Bowel Disorders	<input type="checkbox"/>	<input type="checkbox"/>	23. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
11. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	24. _____	_____	_____
12. Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	25. _____	_____	_____

HOSPITAL ADMISSIONS - List Those Operations & Serious Illnesses Which Required Hospitalization (Excluding Pregnancy)

Year	Reason For Admission/Hospital	Year	Reason For Admission/Hospital

MEDICATIONS - List All Medications You Are Currently Taking (Dosage & Frequency) Include Over-the-counter Drugs, Vitamins & Herbal Remedies


DRUG ALLERGIES

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MENSTRUAL HISTORY    Age At First Period \_\_\_\_\_    Date of Last Period (1<sup>st</sup> Day) \_\_\_\_\_

Period Interval (1<sup>st</sup> Day to 1<sup>st</sup> Day) \_\_\_\_\_    # Days Duration of Bleeding \_\_\_\_\_

CRAMPS - -Yes -No    If Yes, -Mild -Mod -Severe    Always Present - -Yes -No

Start -Before -During -After Bleeding    Medications For Cramps -Yes -No    Type Med \_\_\_\_\_

INFECTIONS - HISTORY OF

-Yeast    -Trichomonas    -Chlamydia    -Herpes    -Gonorrhea    -HPV    -HIV/AIDS    -Syphilis

PAP TEST    Date of Last Test \_\_\_\_\_    -Normal    -Abnormal

MAMMOGRAM    Date of Last Test \_\_\_\_\_    -Normal    -Abnormal

CONTRACEPTIVE HISTORY    Current Method \_\_\_\_\_    If Pill, Brand \_\_\_\_\_

Methods Previously Used \_\_\_\_\_

OBSTETRICAL HISTORY

Number of Times - Pregnant _____						Premature Babies _____		Miscarriages _____		Abortions _____		Living Children _____	
Born Year	Weeks Preg	Weight	Sex	Type of Delivery	Remarks	Born Year	Weeks Preg	Weight	Sex	Type of Delivery	Remarks		
1.						4.							
2.						5.							
3.						8.							

**IMMUNIZATION HISTORY - List Date of Last Immunization or Test**

	Date		Date
Tetanus		Pertussis	
Flu Shot		Hepatitis A/B	
HPV Vaccine		Rubella	

**SOCIAL HISTORY**

Marital Status      -Single      -Married      -Divorced      -Widowed

Smoking            -Yes      -No      Number of Cigarettes/Day \_\_\_\_\_      Number of Years Smoked \_\_\_\_\_

Alcohol            -Yes      -No      Ounces/Week \_\_\_\_\_

Coffee            -Yes      -No      Cups/Day \_\_\_\_\_

Do You Wear Your Seat Belt -Yes      -No

Regular Exercise    -Yes      -No

Recreational Drug Use    -Yes      -No      If Yes, List Type(s) \_\_\_\_\_

Have You Ever Been Hit, Kicked, Slapped or Physically or Sexually Hurt By Anyone      -Yes      -No

Are You Currently Afraid of Anyone Harming You      -Yes      -No

What Age Were You When You First Had Intercourse \_\_\_\_\_

How Many Sex Partners Have You Had in the Last Year \_\_\_\_\_

Date of Last Sexual Intercourse \_\_\_\_\_

Types of Sexual Intercourse You Participate In    -Vaginal      -Oral      -Rectal

Do You Have Sex With    -Male      -Female      -Both

Do You Have Specific Concerns That You May Have Contracted a Sexually Transmitted Disease -Yes      -No

Completed By      -Patient      -Office Staff      -Physician

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**Subsequent Review of History**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_