

## PERSONAL HISTORY FORM

Please bring this form to the office along with a list of *any current medications with name and dosage, including vitamins and supplements.*

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

WHAT BRINGS YOU TO THE OFFICE TODAY? \_\_\_\_\_

ARE YOU PREGNANT? Y N

### GYN HISTORY

First day of your last period: \_\_\_\_\_ Age at first menstruation \_\_\_\_\_ Age at menopause \_\_\_\_\_

Are you **currently** taking birth control pills (patch/ring) Y for \_\_\_\_\_ months/years N

Or hormone replacement therapy? Y for \_\_\_\_\_ months/years N

If not, how often do you get your period? Every \_\_\_\_\_ days; How long does it last? \_\_\_\_\_ days

Do you usually use pain medication with your period? Y N Do you suffer from PMS? Y N Date of last Pap \_\_\_\_\_

Breast exam \_\_\_\_\_ If applicable: Mammogram \_\_\_\_\_ Bone densitometry \_\_\_\_\_ Colonoscopy \_\_\_\_\_

Ever been pregnant? Y N If yes, outcome: # births: \_\_\_\_\_ # Miscarriages, Abortions, Ectopic Pregnancies \_\_\_\_\_

# Living Children \_\_\_\_\_ Any Complications? \_\_\_\_\_

Personal history of GYN disorders, e.g: GYN Cancer/Endometriosis/Fibroids/Excessive Menstruation/Ovarian Cysts

Other \_\_\_\_\_

### SEXUAL HISTORY/RISK ASSESSMENT

Have you ever had sex? Y N Age at first intercourse \_\_\_\_\_

Currently sexually active with men/women/both? (Please circle one)

More than one partner in the last year? Y N What method do you use to prevent pregnancy? \_\_\_\_\_

Have you ever had a sexually transmitted disease? Y N If yes, which? \_\_\_\_\_

Have you ever had an abnormal Pap smear? Y N Colposcopy/Cryo/LEEP? Year \_\_\_\_\_

Have you ever been tested for HIV? Y N Would you like a test today? Y N Would you like tests for other STDs today? Y N

Have you been vaccinated with Gardasil against HPV? Y N

Are you a survivor of sexual assault or incest? Y N Is there violence in any of your relationships? Y N

### PERSONAL MEDICAL HISTORY

Do you have/have you had any medical problems? If yes, please circle:

Anxiety - Asthma ó Allergies - Bleeding Disorder ó Depression- Diabetes- Eating Disorder - Heart Disease -High Blood Pressure High Cholesterol - Migraine Headaches -Thyroid Problems - Seizures Bowel Disease - Urinary Tract Infections

Cancer (which organ? \_\_\_\_\_) Other \_\_\_\_\_

Do you currently take any medications or supplements? If yes, which \_\_\_\_\_

Are you **allergic** to any **medications**? Y N If yes, which \_\_\_\_\_

Have you ever had any **surgery**? Y N If yes, which type? \_\_\_\_\_

### FAMILY MEDICAL HISTORY

Do/did your PARENTS OR SIBLINGS have any of the following? If yes, please circle:

High cholesterol - Stroke - Blood Clots - Diabetes - Heart Disease - High Blood Pressure - Breast Cancer - Uterine Cancer - Ovarian Cancer - Colon Cancer

### HABITS

Do you smoke cigarettes? Y N Do you drink alcohol? Y N Do you use recreational drugs? Y N

