Carson Medical Group

Gynecology Health History Form

Patient Name _____ Date of Birth _____

Gender Identification/Preferred Pronoun _____

Current Medications (Include dose/amount per day)

Medication	Dose/Amount	Frequency

Past Medical History

Check all that apply or: ☐ None

☐ Diabetes ☐ Liver Disease *(Including Hepatitis)* ☐ HIV+

☐ High Blood Pressure ☐ Epilepsy or Seizure Disorder ☐ Eating Disorder

☐ Heart Disease ☐ Blood Clots ☐ Anxiety or Depression

☐ Kidney Disease ☐ Thyroid Disease ☐ Migraines

☐ Gallstones ☐ Asthma ☐ Cancer Type: _____

Medication Allergies

Do you have allergies to medication? ☐ Yes ☐ No

If yes, please list medications and reaction _____

_____

_____

_____

PAP Smear/Mammogram History

Date of last PAP smear _____ Have you had an abnormal PAP smear? ☐ Yes ☐ No

Have you had treatment for an abnormal pap smear? ☐ Yes ☐ No

If yes, what type of treatment? ☐ Cryotherapy ☐ Cone Biopsy ☐ Loop Excision (LEEP)

Year of treatment _____

Date of last mammogram *(month & year)* _____ Have you had an abnormal mammogram ☐ Yes ☐ No

Menstrual History

Age at first menstrual period _____ Age of menopause _____ First day of last menstrual period _____

If your menstrual periods are regular; periods start every _____ days

If your menstrual periods are irregular; periods start every _____ to _____ days (e.g., 12 to 60)

Duration of bleeding _____ days Flow is ☐ Heavy ☐ Regular ☐ Light

Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally

If yes, is it? ☐ Before menses ☐ During menses ☐ Both

Pregnancy History (all pregnancies) Including abortions, miscarriages & ectopic (tubal) pregnancies.

☐ Have never been pregnant

Year	Location	Pregnancy Duration	Delivery Type (Cesarean/ Vaginal)	Complications (Mother/Infant)	Sex (Male/Female)	Birth Weight

Birth Control History

What birth control method(s) do you currently use (including vasectomy)? _____

Sexual/GYN History

Do you have a sexual partner? ☐ Yes ☐ No

If yes: ☐ Male ☐ Female ☐ Both

Please check any that apply or ☐ None

☐ Herpes-genital ☐ Syphilis ☐ Pelvic inflammatory disease ☐ Vaginal infections ☐ Endometriosis

☐ Chlamydia ☐ Gonorrhea ☐ Sexual abuse ☐ HPV ☐ Other _____

Past Obstetrical/Gynecological Surgeries

Check all that apply or: ☐ None

Surgery	Year	Surgery	Year
☐ Dilation & Curettage (D&C)	_____	☐ Myomectomy (Fibroid Removal)	_____
☐ Hysteroscopy	_____	☐ Ovarian Surgery	_____
☐ Infertility Surgery	_____	☐ Left Ovary Removed	_____
☐ Tubal Ligation	_____	☐ Right Ovary Removed	_____
☐ Laparoscopy	_____	☐ Vaginal or Bladder Repair for Prolapse or incontinence	_____
☐ Hysterectomy (Vaginal)	_____	☐ Cesarean Section	_____
☐ Hysterectomy (Abdominal)	_____	☐ Other _____	_____

Past Surgical History (non-Obstetrical/Gynecological)

Please list all surgeries and year or: ☐ None **Year**

_____ _____

_____ _____

_____ _____

_____ _____

Family History

Do you have family history of the following? *If yes, please indicate which family member.*

	Family Member		Family Member
☐ Blood Clots		☐ Uterine Cancer	
☐ Diabetes		☐ Breast Cancer	
☐ Heart Disease		☐ Colon Cancer	
☐ Ovarian Cancer			
☐ Other Family History:			

Social History

Marital Status ☐ Single ☐ Married ☐ Long-term relationship ☐ Divorced ☐ Widowed

Reason for Visit _____

Primary Care Provider _____

Occupation _____

Do you currently?

Smoke or Vape	☐ Yes	☐ No	If yes, number of packs per day? _____
Use Marijuana	☐ Yes	☐ No	If yes, how much and how often? _____
Use Alcohol	☐ Yes	☐ No	If yes, how much and how often? _____
Use Illicit Drugs	☐ Yes	☐ No	If yes, how much and how often? _____

Preventative Care

When was your last?

	Date		Date		Date
Colonoscopy		Flu Vaccine		Gardasil Vaccine	
DEXA (bone density) Scan		Tdap Vaccine		Shingles Vaccine	
Labs		Pneumonia Vaccine		COVID Vaccine	

STOP here if you are not pregnant

If you are currently pregnant, or planning pregnancy in the near future, please continue.

Genetic History

Have you/the father ever had genetic carrier screening? ☐ Yes ☐ No

Are you/the father Italian, Greek, Mediterranean, Asian, African American or Ashkenazi Jewish? ☐ Yes ☐ No

Are you and the father blood related? ☐ Yes ☐ No

Do you/the father have family history of any genetic or chromosome disorders? ☐ Yes ☐ No

If yes, what disorders and what are the relationships to you/the father? _____