Carson Medical Group

Gynecology Health History Form

Patient Name _____ Patient Date of Birth _____

Occupation _____

Are you having any problems or concerns? _____

Gynecologic History

Age at first menstrual period _____ Last menstrual period _____

Number of days between periods _____ Number of days in flow _____

Age of menopause _____ Do you leak urine ☐ Yes ☐ No

Please indicate the areas that apply to you

☐ Pelvic Pain	☐ Gonorrhea	☐ Chlamydia	☐ Irregular Bleeding
☐ Hysterectomy	☐ Herpes	☐ Infertility	☐ Endometriosis
☐ Sexual Abuse	☐ Ovarian Cysts	☐ HPV	☐ Abnormal Pap Smear
☐ Uterine Fibroids	☐ Painful Periods	☐ Pain with Sex	☐ Uterine Ablation

Have you had the HPV vaccination? ☐ Yes ☐ No

Obstetrical History/Past Pregnancies

Please indicate number of

Pregnancies _____ Deliveries _____ Abortions _____ Preemies _____ Stillborns _____

Year	Hospital	Weeks	Hours in Labor	Gender	Delivery Type	Complications

Sexual History

☐ Never	☐ Not Sexually Active	☐ Currently Sexually Active
☐ Male Partner	☐ Female Partner	☐ Multiple Partners

New partner since last visit? ☐ Yes ☐ No

Birth Control Method

☐ None
☐ Birth Control Pills
☐ IUD Type: _____ Date Inserted: _____
☐ Nexplanon Type: _____ Date Inserted: _____
☐ Vasectomy
☐ Condom
☐ NuvaRing
☐ Patch
☐ Abstinence
☐ Tubal Ligation
☐ Essure
☐ Depoprovera
☐ Other: _____

When was your last

Pap Smear _____ Mammogram _____ Colonoscopy _____ Bone Density Scan _____

Labs _____ Flu Shot _____ Tdap Vaccination _____ Pneumococcal Vaccination _____

Allergies and reactions (please include medication, food and environment).

_____

_____

Medical History *Please check the boxes that apply to you*

- ☐ Anxiety
- ☐ Asthma
- ☐ History of Blood Clots
- ☐ Cancer Type: _____
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Gastrointestinal Issues
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ COPD
- ☐ Osteoporosis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder
- ☐ Other: _____

Family History

Were you adopted ☐ Yes ☐ No

	Anemia	Asthma	DVT	PE	Diabetes	Heart Disease	High Blood Pressure	Cancer	List Cancer Type
Mother									
Father									
Siblings									
Grandparents									

Please describe additional family problems you feel is important to your medical history.

Social History

Tobacco Use

☐ Never ☐ Former Smoker (date quit) _____

☐ Daily Smoker ☐ 5 or less/day ☐ 1/2 to 1 pack/day ☐ 1 to 2 packs/day

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Have you had a drink of alcohol in the last year? ☐ Yes ☐ No

How often do you drink ☐ Monthly or less ☐ 2 to 4/month ☐ 2 to 3/week ☐ 4 or more/week

Marijuana Use

☐ Never ☐ Past use ☐ Currently using

Recreational Drug Use

☐ Never ☐ Past use ☐ Currently using What? _____

Current Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Live-in How long? _____

Have you been threatened or physically harmed in the last year? ☐ Yes ☐ No

Do you practice religion ☐ Yes ☐ No

Please list any hospital admissions or surgeries you have had in the past

Please list all current medications/injections including vitamins and over-the-counter medications