

GYNECOLOGIC HISTORY

Name _____ Age menstrual periods began, _____

Are your periods regular? Y or N How often _____

Date of last menstrual period _____ Light or Heavy

Main problem _____

Have you been through menopause? Y or N Is yes, When? _____

Total Pregnancies _____ Premature _____ Stillborn _____ Miscarriage _____

Living Children _____

Any Pregnancy Complications Y or N If so please Describe _____

Date of last Pap Smear _____ Has your Pap Smear Ever Been Abnormal Y or N

Present method of Birth Control _____

Pelvic pain or any pain with intercourse Y or N

Prior pelvic infections? _____ Vaginal Discharge or Irritation? _____

PAST MEDICAL HISTORY

Operations (please list all) _____

Serious Illnesses _____

Other Medical Problems _____

Current Medications _____

Allergies to Medications _____

SOCIAL HISTORY

Cigarette smoker Y or N Estimated Alcohol intake _____

Children's names & Ages _____

Hobbies, Interests _____

FAMILY HISTORY OF MEDICAL PROBLEMS AND SIGNIFICANT ILLNESSES

Father _____ Mother _____ Bro/Sis _____ Children _____

Living Y or N Living Y or N Living Y or N Living Y or N

Do you have a Living Will Y or N

Would you like a Living Will Y or N