GYNECOLOGICAL HISTORY:

How many times have you been pregnant? _____ How many children do you have?_____

Have you ever had any miscarriages, abortions or ectopic (tubal pregnancies)? If so how many?_____

Have you ever been sexually active? (Please circle) Yes No

Are you currently sexually active with anyone? (Please circle) Yes No - Male Female Both

Have you had 5 or more sexual partners in your lifetime? (Please Circle) Yes No

Have you ever had a sexually transmitted disease? Yes No. If Yes what _____

Do you need to be checked for any sexually transmitted diseases today? _____

Do you use contraception (birth control)? _____ If yes what type? (Ex.Condoms,Pills, tubal ligation, IUD,vasectomy) _____

What was the ***first*** day of your last period? _____ Year of Menopause_____

Are you periods regular? ____Yes ____ No. How often do they come? (Ex. Every 28 days) _____

How many days does your period last? _____When was your last Pap Smear?_____

Have you ever had an abnormal Pap Smear?_____

If yes what were the results _____

Have you had any treatment to your cervix? ____Yes ____ No.

If yes what _____ When _____

Have you ever had a bone density test? ____Yes _____No. If yes when_____

Have you ever had a mammogram ____Yes _____No. If yeswhen_____

Have you ever had an abnormal mammogram. ____ Yes ____ No.

If yes what were the results? _____ When _____.

Do you check your breast for lumps? ___yes ___ no. How often?_____. Do you know how?____.

When is the last time you had your cholesterol checked _____ was it Normal ___Yes ___ No

Do you exercise regularly _____ Yes ____ No. If yes what type and how often_____

Have you ever been screened for colon cancer? (Colonoscopy, Sigmoidoscopy etc.) ____ Yes ____ No

If yes when and physician_____ Were the findings normal. _____

If no explain_____

MEDICATIONS:

Please list medications and dosages that you take:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list anything else you would like us to know about your medical situation. _____

_____

_____ _____

Patient Signature **Date**

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