

GYNECOLOGIC HISTORY

Azusa Pacific University

This information will be kept confidential. Please answer honestly so we may give you the best care.

Name _____ Date _____

Allergies-Drugs _____ Environment _____ Food _____

Current Daily Meds: (acne, BCP, depression) _____

Reason for pap today _____

Date of last Pap _____ Abnormal Results? _____ Date of last STI testing _____

Medical History:

Have you ever been hospitalized? Y or N For what _____

Are you currently under the care of a physician? Y or N For what _____

Marital status: Single Engaged Married Divorced

Check all that apply to you or your parents, grandparents, or siblings:

	I have now	I had in past	Family
Blood: Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart: Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misc: Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Issues:			
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal:			
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise Regime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Menstrual History

How old were you when you got your 1st period? _____

FIRST DAY of your last menstrual period (LMP)? _____

How many days does your periods last? _____

How often do you get your period? _____

Do you have spotting or bleeding between periods? Y or N

Do you have a heavy flow? Y or N

How many pads or tampons do you use on your heaviest day? _____

Do you use tampons? Y or N

Do you have severe pain with your period? Y or N

What do you do for the pain? _____

Sexual Activity

Have you ever had vaginal intercourse? Y or N

Approx age of 1st intercourse _____

Approx date of last intercourse _____

Do you have pain or bleeding with intercourse? Y or N

Have you ever been sexually assaulted Y or N

How old were you? _____

Did you get counseling? Y or N

How many sexual partners have you had in your LIFETIME? _____

How many partners in the last year? _____

Have you ever had anal sex? Y or N

Have you ever had oral sex? Y or N

Have you ever been diagnosed with a vaginal infection?

Have you ever been diagnosed with a sexually transmitted infection? Y or N

Circle all that apply: Gonorrhea Chlamydia Syphilis HPV HIV Herpes
Vaginitis/Yeast Bacterial Vaginitis Trichomonas

What do you do to protect yourself from sexually transmitted infections? _____

of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions _____

Contraceptive Practices (Circle all that apply)

Abstinence

Diaphragm

Rhythm

Condoms

BCP

Vaginal Ring

Foam

Patch

IUD

Depo

Do you take birth control pills for any reason other than contraception? Y or N

Acne Cramps PCOS Irregular periods Other _____

Any other problems you want to discuss today? _____

Signature _____

Date _____

Signature of interviewer _____

Date _____