milcom
A Record System for Physicians and Clinics

# Gynecology Health History

ID No.:_____

Today's Date:____ / ____ / ____

## PATIENT IDENTIFICATION *(Please print)*

Patient's Name:_____

Address:_____

_____

Home Telephone No: (  )_____

Work Telephone No: (  )_____

Reason for Seeing Doctor_____

Date of Birth: ____ / ____ / ____ Age: _____ Religion: _____

Marital Status: ☐ S ☐ M ☐ D ☐ SEP ☐ W Race: _____

Education:_____ years Occupation:_____

Employer:_____

Type of Insurance:_____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

## 1. CURRENT MEDICATIONS ☐ None

_____

_____

_____

## 2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ☐ None

_____

_____

_____

## MEDICAL HISTORY *(Check the appropriate box)*

| Have you or any members of your family had: | You | Your Family |
|---|---|---|
| 3. High Cholesterol | ☐ | ☐ |
| 4. Heart Disease | ☐ | ☐ |
| 5. Rheumatic Fever | ☐ | |
| 6. High Blood Pressure | ☐ | ☐ |
| 7. Asthma | ☐ | |
| 8. Tuberculosis | ☐ | |
| 9. Diabetes | ☐ | ☐ |
| 10. Thyroid Problems | ☐ | ☐ |
| 11. Liver Disease | ☐ | |
| 12. Stomach, Bowel or Gall Bladder Problems | ☐ | |
| 13. Kidney or Bladder Problems | ☐ | |
| 14. AIDS (HIV) | ☐ | ☐ |
| 15. Hepatitis (type ___) | ☐ | ☐ |
| 16. Anemia or Blood Disorder | ☐ | ☐ |
| 17. Blood Transfusion | ☐ | |
| 18. Allergies | ☐ | |
| 19. Breast Problems | ☐ | ☐ |
| 20. Cancer | ☐ | ☐ |
| 21. Infertility | ☐ | |
| 22. Female or Sexual Problems | ☐ | |
| 23. Chlamydia | ☐ | |
| 24. Gonorrhea | ☐ | |
| 25. Herpes (HSV) | ☐ | |
| 26. Syphilis | ☐ | |
| 27. Birth Defects or Inherited Diseases | ☐ | ☐ |
| 28. Sexual Abuse or Domestic Violence | ☐ | ☐ |
| 29. Other Medical Problems | ☐ | ☐ |
| 30. **No Known Medical Problems** | ☐ | ☐ |

## 31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ☐ *Do not include pregnancies here.*

| Month/Year | Illness or Operation | Complications Yes | Complications No |
|---|---|---|---|
| / | | ☐ | ☐ |
| / | | ☐ | ☐ |
| / | | ☐ | ☐ |
| / | | ☐ | ☐ |
| / | | ☐ | ☐ |
| / | | ☐ | ☐ |

## SUBSTANCE USE *(Check only those you use)*

32. Alcohol ☐
Type _____
Amt/day _____

33. Tobacco ☐
Type _____
Amt/day _____

34. Caffeine ☐
Type _____
Amt/day _____

35. Non-Prescribed Drugs ☐
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ☐
Type _____
Amt/day _____
Type _____
Amt/day _____

## 37. PREGNANCY HISTORY *(Complete all information)*

| # of Pregnancies | # of Premature Births | # of Miscarriages | # of Spontaneous Abortions | # of Induced Abortions | # of Living Children |
|---|---|---|---|---|---|
| | | | | | |

| # of Term Births | Born Month/Year | Baby's Sex | Weight at Birth | Weeks Pregnant (Term= 40Wks) | Hours In Labor | Type of Delivery | Type of Anesthesia | Complications Yes | Complications No |
|---|---|---|---|---|---|---|---|---|---|
| 1 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 2 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 3 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 4 | / | | lbs. oz. | | | | | ☐ | ☐ |
| 5 | / | | lbs. oz. | | | | | ☐ | ☐ |

## 38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____/____/____

| Menarche (Age at First Period) | Interval (No. of Days Between Periods) | Length of Period |
|---|---|---|
| years | days | days |

Abnormalities: ☐ Excessive Bleeding ☐ Discharge ☐ Pain ☐ None

## 39. CONTRACEPTIVE HISTORY

| Type | | Dates Used |
|---|---|---|
| Oral Contraceptive | ☐ | _____ |
| Type(s) _____ | ☐ | _____ |
| _____ | ☐ | _____ |
| IUD | ☐ | _____ |
| Diaphragm | ☐ | _____ |
| Norplant | ☐ | _____ |
| Sponge | ☐ | _____ |
| Spermicide | ☐ | _____ |
| Condoms | ☐ | _____ |
| Other _____ | ☐ | _____ |

Sterilization ☐ Male ☐ Female

## LIFESTYLE

| | Yes | No |
|---|---|---|
| 40. Did your mother take DES or any other hormones when pregnant with you? | ☐ | ☐ |
| 41. Have you ever had a Pap test? | ☐ | ☐ |
| If Yes: Date of your last Pap test? ___ / ___ /___ | | |
| Have you ever had abnormal Pap test results? | ☐ | ☐ |
| 42. Are you sexually active? | ☐ | ☐ |
| 43. Do you have one partner or | ☐ | one |
| many partners | ☐ | many |
| 44. Is intercourse painful for you? | ☐ | ☐ |
| 45. Do you do a monthly self breast exam? | ☐ | ☐ |
| 46. Have you ever had a mammogram? | ☐ | ☐ |
| If Yes: Date of your last mammogram? ___ / ___ / ___ | | |
| 47. Do you exercise on a regular basis? | ☐ | ☐ |

If Yes: Type of exercise _____

Hours per week exercise _____

Check and detail positive findings below. Use reference numbers.

Signature: _____