

# WOMAN'S CLINIC

NAME \_\_\_\_\_ CHART# \_\_\_\_\_ DATE \_\_\_\_\_  
AGE \_\_\_\_\_

## PAST MEDICAL HISTORY

Do you have or have you ever had: (If yes, list treating physician)

Anemia	_____	Heart disease	_____
Blood clots/phlebitis	_____	Liver disease/hepatitis	_____
Breast disease	_____	Lung disease	_____
Bladder/kidney disease	_____	Anxiety/depression	_____
Cancer	_____	Seizures	_____
Diabetes	_____	Thyroid <small>circle one</small> - hyper/hypo	_____
Hypertension	_____	Other	_____

## PAST GYNECOLOGIC HISTORY (Please Circle)

Have you ever had:

Abnormal Pap Smear	yes	no	_____
Abnormal periods	yes	no	_____
Bartholin cyst	yes	no	_____
Gynecological cancer	yes	no	_____
Endometriosis	yes	no	_____
Fibroids	yes	no	_____
Ovarian cysts	yes	no	_____
Prolapse	yes	no	_____
Urinary incontinence	yes	no	_____
Infertility	yes	no	_____

Is Intercourse Satisfactory? yes no

Have you ever had (circle): Herpes Condyloma Gonorrhea Chlamydia Syphilis

Other Gynecological problems \_\_\_\_\_

## SCREENING TESTS

When was your last Pap smear? \_\_\_\_\_

Have you had a mammogram? yes no When \_\_\_\_\_

Have you had a bone density? yes no When \_\_\_\_\_

Have you had a screening colonoscopy? yes no When \_\_\_\_\_

## PREVIOUS SURGERY (If yes, list surgeon and year of surgery)

	Date		Date		Date
Appendectomy	_____	Breast	_____	Breast Surgery	_____
Cesarean Section	_____	reduction/implants	_____	Gallbladder	_____
Hysterectomy	_____	D&C	_____	Tubal Ligation	_____
Abdominal	_____	Laparoscopy	_____		
Vaginal	_____				
Ovaries removed	_____				
Tonsillectomy	_____				

Other Surgery \_\_\_\_\_

OVER

**ALLERGIES**

Penicillin \_\_\_\_\_  
 Sulfa \_\_\_\_\_  
 Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

**Who in your family has:** (example: mother, father, maternal grandmother/grandfather, paternal grandmother/grandfather)  
 Breast cancer \_\_\_\_\_ Osteoporosis \_\_\_\_\_  
 Colon cancer \_\_\_\_\_ Ovarian cancer \_\_\_\_\_  
 Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_  
 Heart disease \_\_\_\_\_ Thyroid disease \_\_\_\_\_  
 High blood pressure \_\_\_\_\_ Gynecologic cancer \_\_\_\_\_  
 Kidney disease \_\_\_\_\_ Other \_\_\_\_\_  
 Are parents deceased? Yes / No If yes, list cause of death: \_\_\_\_\_

**LIST ALL MEDICATIONS AND DOSAGE**

Medication/Prescribing Physician	Dosage	Medication/Prescribing Physician	Dosage

**GENETIC HISTORY**

Has anyone in your family had any genetic or inherited disorders? \_\_\_\_\_

**PREGNANCY HISTORY**

**Pregnancies**

Total \_\_\_ Full term \_\_\_ Preterm \_\_\_ Miscarriages \_\_\_ Tubal Pregnancies \_\_\_  
 Living Children \_\_\_ Abortions \_\_\_

Date of Birth	Weeks Pregnant	Weight	Sex	Vaginal/ C-section	Anesthesia	Complications	Child Name	Doctor & Delivery Location
1								
2								
3								
4								
5								

**MENSTRUAL HISTORY**

Age of onset \_\_\_\_\_ Frequency every \_\_\_ days  
 Duration of flow \_\_\_\_\_ days Flow: Light \_\_\_ Medium \_\_\_ Heavy \_\_\_  
 Cramps: None \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_  
 Date of last period \_\_\_\_\_ Age of menopause \_\_\_\_\_  
 Birth control method \_\_\_\_\_ Clots \_\_\_\_\_  
 Irregular bleeding Yes \_\_\_ No \_\_\_ on hormones Yes \_\_\_ No \_\_\_

**SOCIAL HISTORY**

Alcohol use? Yes No Occasionally Frequently  
 Drug use? Yes No Explain \_\_\_\_\_  
 Do you exercise? Yes No How often \_\_\_\_\_  
 Marital Status Married Single Divorced Widowed Spouse Name: \_\_\_\_\_  
 Do you Smoke? Yes No How much \_\_\_\_\_ Spouses Occupation \_\_\_\_\_  
 Patients Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Year Married \_\_\_\_\_

**REASON FOR THIS VISIT**

Annual \_\_\_\_\_ Other \_\_\_\_\_  
 Referred by \_\_\_\_\_