

# Women Gynecology & Childbirth Associates, P.C.

**Legal Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Date** \_\_\_\_\_  
First Middle Initial Last  
**Phone Number (work)** \_\_\_\_\_ **(home)** \_\_\_\_\_ **(cell)** \_\_\_\_\_  
**Social Security Number** \_\_\_\_\_ **E-mail address** \_\_\_\_\_

Although some of the information requested may not seem pertinent, it helps us provide for you and under some circumstances to identify illnesses such as sickle cell or TaySachs. This information is **confidential**. It will only be released at your written request. **If you are a minor, we cannot discuss this or your care with your parents without your consent.**

### Family Health History

Has anyone in your family (including grandparents, parents, siblings) ever had the following? Who?

	Yes	No		Yes	No		Yes	No
_____	_____	_____	Heart disease	_____	_____	Cancer	_____	_____
_____	_____	_____	High blood pressure	_____	_____	Diabetes	_____	_____
_____	_____	_____	Stroke	_____	_____	Thyroid disease	_____	_____
_____	_____	_____	Blood clots in legs/lungs	_____	_____	Tuberculosis	_____	_____
_____	_____	_____	High cholesterol	_____	_____	Osteoporosis	_____	_____
								Breast disease
								Birth defects
								Multiple births
								Depression/schizophrenia
								Drug/alcohol abuse

### Medical History: Have you ever had?:

	Yes	No		Yes	No		Yes	No
_____	_____	_____	Breast cancer	_____	_____	Thyroid Disease	_____	_____
_____	_____	_____	Cancer (other)	_____	_____	Hepatitis	_____	_____
_____	_____	_____	High cholesterol	_____	_____	Lung/tuberculosis	_____	_____
_____	_____	_____	High blood pressure	_____	_____	Epilepsy/seizures	_____	_____
_____	_____	_____	Heart disease	_____	_____	Pelvic/hip injury	_____	_____
_____	_____	_____	Gall bladder disease	_____	_____	Asthma	_____	_____
_____	_____	_____	Bowel disease/problems	_____	_____	Ulcer	_____	_____
_____	_____	_____	Bleeding disorder	_____	_____	Hearing Problems	_____	_____
_____	_____	_____	Osteoporosis/Osteopenia	_____	_____	Stroke	_____	_____
_____	_____	_____	Diabetes	_____	_____	Kidney disease	_____	_____
_____	_____	_____	Mitral valve prolapse or heart problems requiring antibiotics for dental work	_____	_____		_____	_____
_____	_____	_____	Other _____	_____	_____		_____	_____
								Multiple sclerosis
								Neurological problems
								Head injury
								Mental health problems (depression/anxiety)
								Drug abuse
								Alcohol abuse
								Migraine Headaches
								Chickenpox
								Headaches
								Glaucoma

### Medication & Allergy History: Are you allergic to?:

	Yes	No		Yes	No		Yes	No
_____	_____	_____	Penicillin	_____	_____	Sulfa	_____	_____
_____	_____	_____	Latex	_____	_____	Iodine	_____	_____
								Other antibiotics/medication
								Other _____

Describe your reaction(s) \_\_\_\_\_

List all **prescribed medicines** you now take \_\_\_\_\_

List all **vitamins and herbs** you take \_\_\_\_\_

Do you take calcium supplements?  yes  no

### Surgery and Hospitalizations: Give year or your age when done.

D and C _____	Cesarean section _____
Appendectomy _____	Tubal ligation _____
Gall bladder _____	Laparoscopy _____
Breast surgery (any type) _____	Hysterectomy _____ Ovaries removed? <input type="checkbox"/> yes <input type="checkbox"/> no
Other gyn surgery _____	Tonsillectomy _____
Have you ever had a blood transfusion? yes _____ no _____	Other hospitalizations _____
When _____	

### Gynecologic History/Immunization History:

Date of last pelvic exam _____	Date of last Pap smear _____	Your weight: _____
Any abnormal pap smears <input type="checkbox"/> yes <input type="checkbox"/> no	Type of treatment _____	Your height: _____
Date and place of last mammogram _____		
Have you had screen for colon cancer (50 years or older) stool blood test, sigmoidoscopy, or colonoscopy?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had genital herpes, chlamydia, gonorrhea or pelvic inflammatory disease?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you currently have vaginal itching or odor?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had your cholesterol checked in the past 3 years?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had a Tetanus shot within the last 10 years?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had a Hepatitis B Vaccine (health care worker or under age 15)?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had the HPV vaccine series? (age 9-26)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you had a measles, mumps, rubella vaccine?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you completed a Health Care Proxy?	<input type="checkbox"/> yes <input type="checkbox"/> no	

**Menstrual History:** (if menstruating)

Date of last period? \_\_\_\_\_  
 How old were you with your first period? \_\_\_\_\_  
 Do you have bad cramps?                    \_\_\_ yes   \_\_\_ no  
 Is heavy flow a problem?                 \_\_\_ yes   \_\_\_ no  
 Do you have PMS?                           \_\_\_ yes   \_\_\_ no  
 Was the last period normal for you?     \_\_\_ yes   \_\_\_ no

Are your periods regular?                 \_\_\_ yes   \_\_\_ no  
 Do you bleed between periods?           \_\_\_ yes   \_\_\_ no  
 Are your periods prolonged more than nine days?   \_\_\_ yes   \_\_\_ no  
 Do you take medicine for cramps?       \_\_\_ yes   \_\_\_ no  
 Do periods/PMS keep you home?         \_\_\_ yes   \_\_\_ no

**Menopause History:** (if menopausal)

Do you have hot flashes?                 \_\_\_ yes   \_\_\_ no  
 Do you have vaginal dryness?            \_\_\_ yes   \_\_\_ no  
 Do you have urinary frequency?         \_\_\_ yes   \_\_\_ no

Have you had a bone density test?       \_\_\_ yes   \_\_\_ no  
 Have you ever used hormone replacement?   \_\_\_ yes   \_\_\_ no  
 Do you have problems with low sex drive?   \_\_\_ yes   \_\_\_ no  
 Do you have loss of urine (incontinence)?   \_\_\_ yes   \_\_\_ no  
 Do you have overactive bladder?         \_\_\_ yes   \_\_\_ no

**Pregnancy History:** (list sex, year of birth, weight and type of delivery)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Living children \_\_\_\_\_ Stillbirths \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Ectopic pregnancy \_\_\_\_\_  
 Did your mother take DES when pregnant with you?           \_\_\_ yes   \_\_\_ no  
 Have you had any complications with pregnancies or abortions?   \_\_\_ yes   \_\_\_ no  
 Have you had problems becoming pregnant?                   \_\_\_ yes   \_\_\_ no

**Sexual History:** (Complete any that apply to you)

Age you started having intercourse \_\_\_\_\_  
 Do you have a male partner?             \_\_\_ yes   \_\_\_ no  
 Do you have a female partner?          \_\_\_ yes   \_\_\_ no  
 Is your sexual activity satisfactory?     \_\_\_ yes   \_\_\_ no  
 Any pain with intercourse?             \_\_\_ yes   \_\_\_ no  
 Is your relationship mutually monogamous?   \_\_\_ yes   \_\_\_ no  
 Do you have other sexual partners?       \_\_\_ yes   \_\_\_ no  
 Does your partner have other partners?   \_\_\_ yes   \_\_\_ no  
 How many partners have you had? \_\_\_\_\_  
 Do you engage in oral sex?               \_\_\_ yes   \_\_\_ no  
 Do you engage in anal intercourse?       \_\_\_ yes   \_\_\_ no

Have you encountered verbal, physical or sexual abuse?                   \_\_\_ yes   \_\_\_ no  
 Are you or your partner using birth control?                   \_\_\_ yes   \_\_\_ no  
 What type? \_\_\_\_\_  
 Are you satisfied with your birth control method?             \_\_\_ yes   \_\_\_ no  
 Has your partner had a vasectomy?                             \_\_\_ yes   \_\_\_ no  
 Does your partner use a condom?                               \_\_\_ yes   \_\_\_ no  
 Do you need information of safe sex practices?               \_\_\_ yes   \_\_\_ no  
 Have any of your partners been at risk for AIDS (heterosexual with multiple partners, bisexual and history of IV drug abuse)?   \_\_\_ yes   \_\_\_ no  
 Do you wish to have HIV testing?                               \_\_\_ yes   \_\_\_ no

**Health Habits:**

Do you smoke?                             \_\_\_ yes   \_\_\_ no  
     How many packs a day? \_\_\_\_\_  
     Have you smoked in the past?       \_\_\_ yes   \_\_\_ no  
     Quit date: \_\_\_\_\_  
 Do you use street drugs?               \_\_\_ yes   \_\_\_ no  
     Have you in the past?               \_\_\_ yes   \_\_\_ no  
     What kind(s) \_\_\_\_\_  
     IV Drug use?                         \_\_\_ yes   \_\_\_ no  
 How much alcohol do you drink? \_\_\_\_\_  
 Do you think you have a problem with alcohol?               \_\_\_ yes   \_\_\_ no  
 Do you have any aesthetic concerns (i.e. hair, skin)?       \_\_\_ yes   \_\_\_ no  
     If so, what are they? \_\_\_\_\_

Do you have body piercing?             \_\_\_ yes   \_\_\_ no  
 Do you have tattoos?                   \_\_\_ yes   \_\_\_ no  
 Do you exercise regularly?            \_\_\_ yes   \_\_\_ no  
 Do you follow a special diet?          \_\_\_ yes   \_\_\_ no  
 Do you eat a balanced diet?            \_\_\_ yes   \_\_\_ no  
 Do you have trouble controlling what you eat?               \_\_\_ yes   \_\_\_ no  
 How do you feel about your current weight? \_\_\_\_\_  
 Do you make yourself vomit?            \_\_\_ yes   \_\_\_ no  
 Do you have a problem with anorexia?   \_\_\_ yes   \_\_\_ no  
 Do you wear seat belts when driving?   \_\_\_ yes   \_\_\_ no  
 Do you see a dentist regularly?        \_\_\_ yes   \_\_\_ no  
 What are you using for sun protection? \_\_\_\_\_

**Social History:**

Education:   \_\_\_ high school           \_\_\_ college           \_\_\_ post graduate  
 \_\_\_ Single   \_\_\_ Married           \_\_\_ Divorced       \_\_\_ Widowed       \_\_\_ Separated       \_\_\_ Living with  
 Race \_\_\_\_\_ Religion \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_  
 Who is your primary care physician? \_\_\_\_\_  
 Other doctors you see? (general and specialists) \_\_\_\_\_  
 What brings you to our office today? \_\_\_\_\_  
 Is there anything you would like to discuss? \_\_\_\_\_

*Guidelines from our Medical Malpractice Insurance carrier require all providers, regardless of gender, to offer a chaperone for any appointment that includes a breast or genital exam. Although we have had no previous issues, we are happy to provide this service.*

Would you like a chaperone during your visit today?   \_\_\_ yes   \_\_\_ no

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