

Gynecologic and Obstetric History

Name of Gynecologist (if you are seeing one): _____
 Age at onset of periods: _____ Frequency: _____ Length of period: _____
 Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____
 Age of menopause: _____ Symptoms of menopause: _____
 Date of last period: _____ Method of birth control: _____
 Do you take, or have you ever taken, hormone replacements or birth control pills? _____
 Describe: _____
 Have you had other gynecologic problems? _____ Describe: _____
 Last Mammogram: _____
 Last Pap Smear: _____
 Last DEXA (bone density) scan: _____

Family History

Family member	Living?	Age	Cause of Death	Other Illnesses
Grandparents				
Father				
Mother				
Siblings				
Children				

Prevention

Last Sigmoidoscopy or Colonoscopy: _____
 Do you take aspirin regularly? _____ How much? _____
 Do you take calcium regularly? _____ How much? _____
 Last Flu shot (influenza): _____
 Pneumonia shot (Pneumovax): _____
 Meningococcus Meningitis vaccine (Menomune): _____
 Last Tetanus shot: _____
 Have you had the Hepatitis B series of shots? _____ When? _____
 Do you have an Advance Directive, Living Will, etc.? _____ If so, we would like a copy to keep in your medical record.
 Do you have an organ donor card? _____
 Do you smoke? _____ How much? _____
 Do you drink alcohol? _____ How much? _____
 Do you use any recreational drugs? _____ Which? _____
 What exercise do you do? _____
 Do you wear a seatbelt? _____
 Do you wear sunscreen when out in the sun? _____