Today's date**:**_____

GYNECOLOGY CONSULTATION

Patient name: _____Date of birth:_____Age:_____Height:_____

Occupation:_____

Please note the reason for your visit today: _____

LIST ALL PAST MEDICAL HISTORY**:**

_____

_____

GYNECOLOGIC HISTORY:

Date of last pap:_____/_____/_____ Have you had any abnormal paps? _____

SURGICAL/HOSPITALIZATION HISTORY

List all hospitalization, operations or major injuries (excluding pregnancy) include dates if possible:

ALLERGIES:

Please note any allergies or reactions to medications or other agents. None ☐

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

CURRENT PRESCRIPTION MEDICATIONS:

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS. ☐ **None**

Med/Dose: _____
Med/Dose: _____
Med/Dose: _____
Med/Dose: _____

GYNECOLOGIC STATUS

Menstrual History: **Please circle your answer**

Date your last period began: _____ Was it normal? • no • yes

How often are your periods? _____ How many days does your period last? _____

Flow: • heavy • average • light

Do you think you have a problem with your period? • no • yes -Explain: _____

What method of birth control are you using? _____

Post-Menopausal: (skip if your are pre-menopausal)

Post Menopausal since age: _____ Have you ever been on Hormone Replacement Therapy? • no • yes
Why or why not? _____ If so for how long? _____
Are you experiencing any vaginal bleeding? • no • yes

Sexual History:

Have you ever had sex or been sexually active? • Yes • No If yes, are you currently having sex? •Yes • No

What sex is your partner(s):_____
Have you or your partner(s) had new sexual partners since your last STD/STI test?• Yes • No
Do you have concerns about sexually transmitted infections? •Yes • No •Unsure
Do you have concerns about sex or your sexual health? •Yes • No
Do you have concerns about vaginal dryness or pain with intercourse? •Yes • No
Do you have concerns about libido? •Yes • No

OBSTETRICAL HISTORY: Please list all pregnancies

Date(mo/yr)	Type of delivery (vaginal/ C-section)	If applies: Miscarriage or abortion	Weight	Gender

Family History: Please list any major medical problems in your family?

Any family history of breast cancer, ovarian cancer or blood clots?_____

Mother	Father	Siblings	Other

Have you ever been diagnosed with any of the following □ None

- •Anemia
- •Bleeding between periods
- •Blood Clots
- • Bacterial vaginosis
- • Cancer: _____
- • Chlamydia/ gonorrhea
- •Depression
- • DES Exposure in Utero (when your mother was pregnant with you)
- • Endometriosis
- • Fibroids
- • Headache (migraine)
- • Hepatitis/Jaundice
- •Herpes
- • HIV/AIDS
- • Hypertension (high blood pressure)
- • Infertility
- • Osteoporosis
- • Ovarian Cyst
- • Pelvic Pain, chronic
- • Painful periods (dysmenorrhea)
- • Pain with sex(dyspareunia)
- • Pelvic Inflammatory Disease (PID)
- • Polycystic ovarian Syndrome (PCOS)
- • STI/Sexually Transmitted Infections
- • Urinary Tract Infection (UTI)
- • Urinary Incontinence
- • Vaginal dysplasia (precancer)
- • Vulvar dysplasia (precancer)
- • Yeast
- • Other:_____