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GYNECOLOGY HISTORY FORM

NAME: _____

TODAY'S DATE: _____

AGE: _____ OCCUPATION: _____ PRIMARY HEALTH CARE PROVIDER: _____

A. MENSTRUAL HISTORY

- Age at first period: _____ Date last period started: _____ Was it normal? yes ___ If no, explain: _____
- Have you reached menopause: no ___ If yes, circle how menopause occurred & go to section "B": naturally surgically/uterus removed/ovaries removed
- Do you usually have a period every 26-35 days: yes ___ If no, what is your usual pattern: _____
- How many days do you usually flow (menstruate): _____ Flow is usually: (list number of days of each) light ___ moderate ___ heavy ___ clots ___
- Do you usually have cramps with your period: no ___ If yes, are they: mild ___ moderate ___ severe ___ What do you use for relief: _____

B. OBSTETRICAL HISTORY

PLEASE LIST ANY PREGNANCIES YOU HAVE HAD STARTING WITH YOUR FIRST PREGNANCY.									
#	Pregnancy ended Month/year	Weeks pregnant	How pregnancy ended*	ANY PREGNANCY AFTER 20 WEEKS				Complications	
				Type of delivery	Baby's birth weight	Baby's sex	Is this child living now?	No	Yes, please list
1					lb oz				
2					lb oz				
3					lb oz				
4					lb oz				
5					lb oz				
6					lb oz				

* List one of the following: abortion, miscarriage, ectopic(tubal), stillbirth, premature (36wks or before), full term (37wks or after)

C. HOSPITALIZATIONS

STARTING WITH THE MOST RECENT, LIST ANY HOSPITALIZATIONS NOT LISTED ABOVE. Check here if more than four: _____		
Month/year	ILLNESS OR OPERATION	COMPLICATIONS
		No Yes, please list

D. CHILDBEARING/FAMILY PLANNING - If you have already reached menopause, check here and move to section "E": _____

- Have you ever thought you were infertile or were you ever diagnosed with a fertility problem: no ___ If yes, explain: _____
- Are you planning to get pregnant in the future: no ___ If yes, what are your plans: _____
- Are you using a birth control method(s) now: no ___ If yes, what are you using: _____
- Have you used any other birth control method(s) in the past: no ___ If yes, what: _____
- Do you want a birth control method at your visit here: no ___ If yes, what method(s): _____
- Have you ever had any problem, complication or unexpected pregnancy while using a birth control method: no ___ If yes, explain: _____
- Is there any assistance you need in making or achieving your reproductive goals: no ___ If yes, how can we assist you: _____

E. FAMILY HEALTH HISTORY

PLACE A CHECK IN THE APPROPRIATE BOX IF EITHER YOU OR A FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:	SELF	NATURAL MOTHER	NATURAL FATHER	NATURAL GRAND-MOTHER	NATURAL GRAND-FATHER	NATURAL BROTHER SISTER	CHILD
1. Heart attack or stroke before age 50							
2. Diabetes, diagnosed by a physician, including diabetes in pregnancy							
3. High blood pressure							
4. Cardiovascular (heart/blood vessel) disease or cholesterol problems							
5. Cerebrovascular (brain/blood vessel) disease							
6. Cancer of any kind, in any organ							
7. Genetic or hereditary conditions (PKU, sickle cell, Tay sachs, hemophilia, other blood clotting disorders, etc.)							

F. PERSONAL HEALTH HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:	NO	YES	IF YES, BRIEFLY EXPLAIN
1. lung disease			
2. anemia or blood disorders			
3. liver disease or hepatitis			
4. gallbladder, stomach or bowel problems			
5. varicose veins			
6. thyroid problems			
7. epilepsy or seizures			
8. visual problems, eye disorders, corrective lenses or contacts			
9. migraine or severe headaches			
10. severe or prolonged depression, mental or emotional problems			
11. eating disorder/bulimia or anorexia			
12. blood clots or infection in your veins			
13. breast disease or problems			
14. persistent pain or bleeding with intercourse			
15. uterine abnormalities, fibroids or polyps			
16. abnormal pap smear colposcopy, biopsy, freezing(cryo), laser or conization			
17. pelvic infection (PID)			
18. vaginal infection			
19. chlamydia, gonorrhea or syphilis			
20. herpes			
21. venereal warts/genital warts/HPV			
22. Any other sexually transmitted disease (STD)?			
23. Any other serious illness not mentioned above?			
24. Do you want or need STD testing at your visit?			
25. Do you have any drug or medication allergies?			
26. Are you taking any drugs or medications?			
27. Do you smoke?			If yes, cigarettes per day: _____ Packs per day: _____
28. Any substance abuse problems (drugs or alcohol)?			
29. Do you have any symptoms of a vaginal infection?			
30. Did your mother take DES when pregnant with you?			
31. Do you lose urine with a cough, sneeze or laugh?			
32. Do you have any problems or questions regarding your sexuality?			
33. Do you have any gynecologic (female) problems or concerns today?			If yes, is this a new problem?
34. Is there anything else you would like us to know for your visit or to assist you in your health care?			

We are pleased that you have chosen this office for your Ob/Gyn care. We want to assist you by providing quality medical care and information concerning fertility, birth control and family planning, care related to pregnancy, women's cancer prevention & detection, menopause and all aspects of women's health that relate to the reproductive system and sexuality. We invite you to consult with us concerning any questions you may have and allow us to assist you in meeting your health care needs. We do not provide general health care unrelated to Ob/Gyn concerns and we encourage you to obtain regular medical evaluations with your primary health care provider/family doctor. If you do not have a primary health care provider, we would be happy to provide you with a referral.

YOUR SIGNATURE: _____

TODAY'S DATE: _____

FOR OFFICE USE ONLY	
SIGNATURE: _____	DATE: _____

Personal/Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
 Date of Birth: _____ Date: _____

Instructions: Please circle **Y** to those that apply to **YOU** and/or **YOUR FAMILY** (on both your **mother's** or **father's** side). Next to each statement, please list the **relationship to you** of the individual diagnosed (such as self, paternal aunt, maternal uncle, paternal grandmother) and their **age of diagnosis**. Answer each statement individually – you may list the same cancer diagnosis more than once as you answer each question. This is a screening tool for the common features of hereditary cancer syndromes. If you circle **Y** to any of the statements below, you **MAY** be appropriate for genetic testing. Ask your healthcare provider for additional information.

BREAST AND OVARIAN CANCER:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50		
Y	N	Ovarian cancer		
Y	N	Breast cancer in both breasts or multiple primary breast cancers		
Y	N	Both breast and ovarian cancer in an individual OR a family		
Y	N	Male breast cancer		
Y	N	2 or more breast or ovarian cancers in an individual OR family		
Y	N	Ashkenazi Jewish ancestry and a personal or family history of breast or ovarian cancer		

COLON AND UTERINE CANCER:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50		
Y	N	Colon cancer before age 50		
Y	N	Both uterine and colon cancer in an individual OR a family		
Y	N	2 or more uterine or colon cancers in an individual OR family		
Y	N	Uterine AND/OR colon cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family		
Y	N	10 or more colon polyps found in a lifetime		

MELANOMA:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	2 or more melanomas in an individual or family		
Y	N	Both melanoma and pancreatic cancer in an individual or family		

FOR THE HEALTHCARE PROVIDER:

<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing <input type="checkbox"/> Information given to patient to review <input type="checkbox"/> Follow up appointment scheduled: _____ <input type="checkbox"/> Patient offered genetic testing: <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
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Patient's Signature: _____ Date: _____
 Health Care Provider's Signature: _____ Date: _____