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GYN Medical Assessment

Name _____ Date _____ Chart No. _____

I authorize this information is true & accurate: _____
Complete page 2. Patient Signature

Menstrual History

1. What are the dates of your last 2 menstrual periods? 1. _____ 2._____
2. How many days does your period normally last? ____ Is flow: ____Light ____Moderate ____Heavy
3. How many days between periods? (count from start of period to start of next period) _____
4. Pain or cramps? ___Y ___N If yes, when in cycle, and what medications:_____
5. How old were you when you had your first period?_____

Obstetrical History

Number of Pregnancies____ Full Term____ Premature___ Miscarriages____ Abortions___

Please list each pregnancy, including all information such as type delivery (vaginal or c-section), and include sex and condition of baby. Include miscarriages and abortions.

Date	***Place***	***Type (vag, c-sec,etc)***	***Anesthesia***	***Labor***	***Complications***	***Wt.***	***Baby***
_____	_____	_____	_____	_____	_____	____	_____
_____	_____	_____	_____	_____	_____	____	_____
_____	_____	_____	_____	_____	_____	____	_____
_____	_____	_____	_____	_____	_____	____	_____
_____	_____	_____	_____	_____	_____	____	_____
_____	_____	_____	_____	_____	_____	____	_____

Past Medical History

Allergies to medicines:_____
Are you being treated for any illnesses or conditions by any other physician? ____Y ___N
If yes, explain: _____
_____

Are you currently taking any medications, including birth control pills: ____Y ____N
If yes, please list: _____

Do you smoke cigarettes? ___Y ___N … if yes, how many per day?_____
Do you drink alcohol? ___Y ___N … if yes, how much per day?_____
Have you ever used illicit drugs? ___Y ___N… if yes, explain:_____
Ever had blood transfusion ___Y ___N … if yes, when?_____

Please list all non-Obstetrical hospitalizations, surgeries, and outpatient surgeries.

Date	***Place***	***Diagnosis***	***describe Surgery or Medical Care***	***M.D.***
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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Have you ever had any of the following?

Yes	No		Yes	No	
___	___	Measles, mumps	___	___	Kidney or Bladder problems
___	___	Chickenpox	___	___	Thyroid Disease
___	___	Cancer	___	___	Blood Clots in legs or lungs
___	___	Migraines	___	___	Seizures
___	___	High Blood Pressure	___	___	Mental Problems or depression
___	___	Diabetes	___	___	Blood Diseases
___	___	Heart Disease	___	___	Sexually-Transmitted Diseases
___	___	Lung Disease	___	___	Endometriosis

Do you perform monthly self-breast exam? _____
When was your last mammogram?_____ Result_____
Do you check your skin regularly for any abnormalities?____
Have you had a tetanus shot in the last 10 years?_____
Are you considering pregnancy in the future?____
If yes, have you had or been vaccinated against chicken pox? _____
And are you immune to German measles (Rubella)?____
Have you had a cholesterol test in the last 5 years? _____ …. If yes, When_____ Result_____
Do you wear seat belts?____
Do you exercise?_____ How much_____

Family History

Has your family history changed in the past year?___Y ____N

Has anyone in your family ever had any of the following?

Cancer (list relative and type of cancer)_____
Heart Disease before age 55_____
High Blood Pressure or Stroke_____
Diabetes_____
Endometriosis, Uterine Fibroids_____
Any other medical problems_____

Review of Systems (Please circle if you *currently* have any of the following).

1. General Symptoms: Fever, sweats, fatigue, eating disorder, significant weight change.
2. Skin: Change in moles, new moles, skin lesions
3. Eyes: Change in vision, problem requiring visit to a physician.
4. Breasts: Lumps, pain, swelling, discharge, blood, trauma.
5. Respiratory System: Unexplained cough, coughing blood, wheezing, pain.
6. Cardiovascular System: Chest pain, short of breath (with exertion or not), palpitations, irregular.
7. Gastrointestinal System: Unexplained nausea, vomiting, vomit blood, constipation, diarrhea, pain, change in bowel habits, change in stool color (tarry, bloody), abdominal pain or jaundice.
8. Genitourinary System: Lose urine with cough/sneeze, urinate more frequently, bloody urine, pain.
9. Reproductive System: Abnormal bleed, pelvic pain, sexual dysfunction/pain, vaginal discharge, itching, burning
10. Musculoskeletal System: Joint pain, swelling, muscle, weakness, trauma, fracture.
11. Lymph Nodes: Enlargements or pain.
12. Nervous System: Numb or sensory change, paralysis, weakness, new headache, feeling depressed or mood problems

Physician Signature _____