Date _____

Gynecologic History Form

Name: _____ Age: _____ Marital Status _____

Date of onset of last menstrual period? _____ Age of onset of menstrual cycle? _____
Last pap smear? _____
Are you sexually active? Y N
Birth control measures currently in use? _____
Are you currently taking any medications? Y N
If so, please specify... _____

During your menstrual cycle...

How many days do you flow? _____
Describe the character of your usual period. Heavy Medium Light
Do you have pain with your menstrual cycle? Y N
What is the average length of days between periods? _____
Are your periods regular? Y N
Do you consider your flow to be excessive? Y N

Pregnancy History

Number of times pregnant? _____
Number of children born at term? _____
Number of children born preterm? _____
Number of abortions?(miscarriage or therapeutic) _____
Number of currently living children? _____
Have you had any complications with your pregnancies? Y N
If yes, please specify. _____

Gynecologic History

Have you ever had the following...

Herpes(Genital) Y N
Venereal Warts Y N
Gonorrhea Y N
Syphilis Y N
Recurrent Yeast Infections Y N
Pelvic Inflammatory Disease (PID) Y N
Other: please specify. _____

Have you ever had a colposcopy procedure performed? Y N
Have you ever had an abnormal Pap smear? Y N
Have you ever had gynecologic surgery? Y N
If yes, please specify. _____

Family History and Social History

Is there any family history of... (please specify relative)

Breast Cancer Y N Who? _____
Endometrial cancer Y N Who? _____
Cervical cancer Y N Who? _____
Other (please specify)

Do you smoke? _____ How many packs per day? _____ For how many years? _____
Have you ever used IV drugs? Y N

Patient Signature _____