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Minimally-Invasive Gynecology

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WOMEN'S HEALTH HISTORY

Patient Name ______________________________________Date of Birth ____________ Date Form Completed_____________
-
Reason for today's visit: ____

____

____

____

ALLERGIES:____Referred by:__________________________________

Current Medications:____

GYNECOLOGIC HEALTH HISTORY Date of last PAP smear: ________________ Results: _____________

First day of last period: _________________ Date of last mammogram: _______________ Results: _____________

Are your periods regular? ‽ Yes ‽ No ‽ N/A Have you ever had an abnormal PAP? ‽ Yes ‽ No When:____________________

Are they heavy? ‽ Yes ‽ No ‽ N/A

Are they painful? ‽ Yes ‽ No ‽ N/A

Have you ever had sex? ‽ Yes ‽ No Sexual partners are: ‽ Men ‽ Women ‽ Both

How many times have you been pregnant? ____________

How many children do you have? ____________ G______P______Ab______

Have you had any miscarriages? ‽‽‽ Yes ‽‽‽ No Abortions? ‽‽‽ Yes ‽‽‽ No

MEDICAL & SURGICAL HISTORY

Medical Illnesses (diabetes, high BP,etc)____

Prior Surgical history (with dates)?____

____

Do you currently, or have you in the past used: Previously Currently

Tobacco ‽ Yes ‽ No ‽ ‽ Yes ‽ No Frequency: _________________

Alcohol ‽ Yes ‽ No ‽ ‽Yes ‽ No Frequency: _________________

Street Drugs (incl marijuana) ‽ Yes ‽ No ‽ Yes ‽ No Frequency: _________________

FAMILY HISTORY

Have any relatives had the following?

Cancer ‽ℯ𝓇⊱⑩ ‽☟⑥

Who?____

High Blood Pressure / Heart Disease ‽ Yes ‽ No Who?____

Osteoporosis ‽ Yes ‽ No Who?____

Gynecologic Problems _ Yes _No Who?____

Other:____

____

_______________________________________ _______________________________________ ________________________

Patient Signature Print Name Date