GYN Patient History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Pharmacy: _____

Date of last PAP: _____	PAP result: ☐ Normal ☐ Abnormal	
History of abnormal PAPs: ☐ No ☐ Yes – if yes, when: _____		
Date of HPV Testing: _____	HPV result: ☐ Normal ☐ Abnormal	Received HPV vaccine: ☐ Yes ☐ No
Sexual Partners: ☐ Male ☐ Female ☐ Both	Currently sexually active: ☐ Yes ☐ No ☐ Never	

A. GYN Procedures

☐ Colposcopy
Dates: _____
☐ Cryotherapy
Dates: _____
☐ Cone Biopsy
Dates: _____
☐ LEEP
Dates: _____
☐ Hysterectomy
Dates: _____
☐ Tubal ligation/Salpingectomies
Dates: _____
☐ Ovaries Removed: ☐ Both ☐ One
Dates: _____
☐ Bladder Sling
Dates: _____
Other GYN Surgical Procedures:
Type: _____
Date: _____

B. OB History

History of infertility: ☐ Yes ☐ No
Number of Pregnancies: _____
Number of Abortions: _____
Number of Miscarriages: _____
Number of full term births: _____
Number of Preterm births: _____
How many live children: _____
How many Vaginal deliveries: _____
How many Cesarean deliveries: _____

C. Menopause

Menopausal: ☐ No ☐ Yes – if yes, age menopause began: _____
Symptoms: _____

NOTE: Skip sections D & E if post-menopausal

D. Menstrual History

Periods are _____ days apart
Menstrual bleeding lasts _____ days
First day of last period: _____
Age of first started period: _____
How many pads or tampons are you using per day? _____
Painful periods: ☐ Yes ☐ No
If yes: ☐ severe ☐ moderate ☐ mild
Quantity of bleeding:
☐ Heavy ☐ Medium ☐ Light

E. Current Birth Control Method

☐ None
☐ Abstinence
☐ Cervical Cap
☐ Withdrawal
☐ Condom
☐ Diaphragm
☐ IUD _____
☐ Implant
☐ Birth Control Pills
☐ Patch
☐ Natural Family Planning
☐ Spermicide
☐ Sponge
☐ Surgical
☐ Tubal Ligation
☐ Vaginal Ring
☐ Partner Vasectomy
☐ Depo Provera (injection)

F. History of STDs

☐ None
☐ HPV
☐ Genital Warts/Condyloma
☐ HSV
☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Trichomonas
☐ Pelvic Inflammatory Disease
☐ Syphilis

Treated: ☐ Yes ☐ No

# of partners in lifetime: ____
Age of first sexual contact: ____

Reason for your visit:

_____

_____

Completed by:

Patient/Representative Signature: _____ Date: _____ Time: _____

Relation to patient: _____

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Patient Label