Grand River Medical Center

CONFIDENTIAL
Gynecology Medical History

Patient Name _____ Age _____ Birth Date _____-_____-_____

Today's Date _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Why is Patient here today? _____

History Information supplied by: ☐ Self ☐ Other _____ Referred by _____

Is patient allergic to or had any adverse reaction to any medications, foods, shell fish or dyes: ☐ Yes ☐ No
If yes, list _____

Is patient taking any prescription meds? ☐ Yes ☐ No If yes, list:	Is patient taking any non-prescription medications? (for example, aspirin, vitamins, herbal supplements or calcium) ☐ Yes ☐ No If yes, list:	Has patient had any surgeries? ☐ Yes ☐ No Year: _____ Type of Surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What type of work does patient do? _____ ☐ Full Time ☐ Part Time ☐ Retired
Hobbies _____

Does patient exercise? ☐ Yes ☐ No What type? _____
How often? ☐ Seldom ☐ Sometimes ☐ Weekly ☐ Daily
How long? ☐ 0 - 15 minutes ☐ 15 - 30 minutes ☐ 30 minutes or more

Does patient use tobacco? ☐ Yes ☐ No ☐ Quit _____ years ago
Type: ☐ Cigarette Packs per day _____ for _____ years ☐ Other _____

Does patient drink alcohol? ☐ Yes ☐ No ☐ Quit _____ years ago Type: ☐ Beer ☐ Wine ☐ Liquor
How often did or does patient drink? ☐ Seldom ☐ Sometimes ☐ Weekly ☐ Daily

Has patient ever used street drugs? ☐ Yes ☐ No If yes, type: ☐ Cocaine ☐ Marijuana ☐ Inhalants ☐ Other

Health History

Has patient, **Parents**, **Grandparents**, **Siblings** or **Children** had or have any of the following? Mark a ✓ by all that apply

	Patient	Family		Patient	Family
1. Colon Cancer			18. Tuberculosis		
2. Breast Cancer			19. Migraine Headaches		
3. Uterus Cancer			20. Seizures		
4. Ovary Cancer			21. Mental Disorder		
5. Other Cancer			22. Kidney Disease		
6. Diabetes			23. Intestinal Disease		
7. Thyroid Disease			24. Arthritis		
8. Stroke			25. Muscle Disease		
9. Heart Disease			26. Bone Fracture		
10. Hypertenstion			27. Osteoporosis		
11. High Cholesterol			28. Surgical Complication		
12. Blood Clot in Vein			29. General Female Probs		
13. Bleeding Tendency			30. Use of Ibuprofen		
14. Blood Transfusion			31. Use of Warfarin		
15. Anemia			32. Use of Plavix		
16. Asthma			33. Diabetes During Pregnancy		
17. Lung Disease			34. Other		

For Office Use Only

Please Turn Over

CONFIDENTIAL
Personal Health Information

Patient Name: Date:

Have you had DES exposure? ☐ Yes ☐ No
Have you had a recent weight gain or loss? ☐ Yes ☐ No
Do you have problems with excessive hair growth? ☐ Yes ☐ No
Do you have pelvic infections or chronic vaginal discharge? ☐ Yes ☐ No
Do you have problems with pelvic pain? ■ Yes ☐ No
Do you experience vaginal dryness? ☐ Yes ☐ No
Are you currently sexually active with a male partner? ☐ Yes ☐ No
Is sex painful? ☐ Yes ☐ No
Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
Age of first sexual intercourse? _____
Number of lifetime sex partners? _____
Do you perform breast exams? ☐ Yes ☐ No
Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Gynecology Information

Age of 1st menstrual period _____
First day of last menstrual period _____
Number of days on period _____
Length of cycle (First day of one to the first day of the next) _____

Have your periods been regular? ☐ Yes ☐ No
The average flow is: ☐ Light ☐ Moderate ☐ Heavy
Do you have pain with periods? ☐ Yes ☐ No

Obstetrical History

Number of times pregnant _____ ☐ N/A
Number of living children _____ ☐ N/A
Number of miscarriages _____ ☐ N/A
Number of full term births _____ ☐ N/A
Number of premature births _____ ☐ N/A
Number of abortions _____ ☐ N/A
Number of cesarean sections _____ ☐ N/A

Weight of largest baby _____
Any complications of pregnancy or birth? _____
Are you and your partner using any method to prevent pregnancy? _____
If yes, what type? _____
Are you planning pregnancy in the future? ☐ Yes ☐ No

Hormone Use

Have you ever been on hormone replacement? ☐ Yes ☐ No
Do you experience hot flashes? ☐ Yes ☐ No
Do you experience night sweats? ☐ Yes ☐ No

Health Screen Status

Date of last pap smear _____
Date of last mammogram _____
Have you had Osteoporosis screening? ☐ Yes ☐ No
Have you had colon cancer screening? ☐ Yes ☐ No
Have you had cholesterol screening? ☐ Yes ☐ No
Results of cholesterol screening? _____

Vaccination Status

Date of last Tetanus booster? _____
Date of last Diphtheria booster? _____
Date of Pneumococcal vaccine? _____
Date of Herpes Zoster vaccine? _____
Date of last Pertusis booster? _____

Bladder Function

Do you experience frequent urinary tract infections? ☐ Yes ☐ No
Do you have painful urination? ☐ Yes ☐ No
Do you experience frequent urination? ☐ Yes ☐ No
Do you experience sensation of incomplete voiding? ☐ Yes ☐ No
How many times do you urinate at night? _____
Have you experienced loss of urine with cough, sneeze, straining, laughing or other activity? ☐ Yes ☐ No
Do you wear a pad or protection because of wetness? ☐ Yes ☐ No