milcom
A Record System for Physicians and Clinics

Gynecology Health History

ID No.: ______

Today's Date: ____/____/____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: ______

Address: ______

Home Telephone No: ( ) ______

Work Telephone No: ( ) ______

Reason for Seeing Doctor ______

Date of Birth: ___/___/___ Age: ___ Religion: ___

Marital Status: ☐ S ☐ M ☐ D ☐ SEP ☐ W Race: ___

Education: ___ years Occupation: ___

Employer: ___

Type of Insurance: ___ Policy #: ___

Referring Physician: ___

Primary Physician: ___

1. CURRENT MEDICATIONS ☐ None

______

2. MEDICATION ALLERGY/ SENSITIVITY

List all medications allergic to: ☐ None

______

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:

	You	Your Family
3. High Cholesterol	☐	☐
4. Heart Disease	☐	☐
5. Rheumatic Fever	☐	
6. High Blood Pressure	☐	☐
7. Asthma	☐	
8. Tuberculosis	☐	
9. Diabetes	☐	☐
10. Thyroid Problems	☐	☐
11. Liver Disease	☐	
12. Stomach, Bowel or Gall Bladder Problems	☐	
13. Kidney or Bladder Problems	☐	
14. AIDS (HIV)	☐	☐
15. Hepatitis (type ___)	☐	☐
16. Anemia or Blood Disorder	☐	☐
17. Blood Transfusion	☐	
18. Allergies	☐	
19. Breast Problems	☐	☐
20. Cancer	☐	☐
21. Infertility	☐	
22. Female or Sexual Problems	☐	
23. Chlamydia	☐	
24. Gonorrhea	☐	
25. Herpes (HSV)	☐	
26. Syphilis	☐	
27. Birth Delecis or Inherited Diseases	☐	☐
28. Sexual Abuse or Domestic Violence	☐	☐
29. Other Medical Problems	☐	☐
30. No Known Medical Problems	☐	☐

31. HOSPITALIZATIONS

List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ☐ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	Complications No
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ☐
Type ___
amt/day ___

33. Tobacco ☐
Type ___
amt/day ___

34. Catteine ☐
Type ___
amt/day ___

35. Non-Prescribed Drugs ☐
Type ___
Amt/day ___
Type ___
Amt/day ___

36. Street Durgs ☐
Type ___
Amt/day ___
Type ___
Amt/day ___

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	Complications No.
1	/		lbs. oz.					☐	☐
2	/		lbs. oz.					☐	☐
3	/		lbs. oz.					☐	☐
4	/		lbs. oz.					☐	☐
5	/		lbs. oz.					☐	☐

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ___/___/___

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ☐ Excessive Bleeding ☐ Discharge ☐ Pain ☐ None

39. CONTRACEPTIVE HISTORY

Type		Dates Used
Oral Contraceptive	☐	
Type(s) ___	☐	
___	☐	
IUD	☐	
Diaphragm	☐	
Norplant	☐	
Sponge	☐	
Spermicide	☐	
Condoms	☐	
Other ___	☐	

Sterilization ☐ Male ☐ Female

LIFESTYLE

	Yes	No
40. Did your mother take DES or any other hormones when pregnant with you?	☐	☐
41. Have you ever had a Pap test?	☐	☐
If Yes: Date of your last Pap test? ___/___/___		
Have you ever had abnormal Pap test results?	☐	☐
42. Are your sexually active?	☐	☐
43. Do you have one partner or	☐	one
many partners	☐	many
44. Is intercourse Painful for you?	☐	☐
45. Do you do a monthly self breast exam?	☐	☐
46. Have you ever had a mammogram?	☐	☐
It Yes: Date of your last mammogram? ___/___/___		
47. Do you exercise on a regular basis?	☐	☐
If Yes: Type of exercise ___		
Hours per week exercise ___		

Check and detail positive findings below. Use reference numbers.

Signature: ______

Gynecology Health History

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Today's Date: ____ / ____ / ____

INITIAL PHYSICAL EXAM

1. Height ______________________
2. Weight ______________________
3. Blood Pressure ______________________

Pelvic Exam	Normal	Abn.	N.E.
4.Ext. Genitalia			
5.Urethral Meatus			
6.Urethra			
7.Bladder			
8.Vagina			
9.Cervix			
10.Uterus (describe)			
11.Adnexa/Parametria			
12.Rectum (Digital Exam)			
13.Anus and Perineum			
14.Other			

General Physical	Normal	Abn.	N.E.
15.Skin			
16.HEENT			
17.Neck			
18.Chest			
19.Breasts			
20.Heart			
21.Lungs			
22.Abdomen			
23.Musculoskeletal			
24.Extremities			
25.Neurological			

Nutritional Assessment

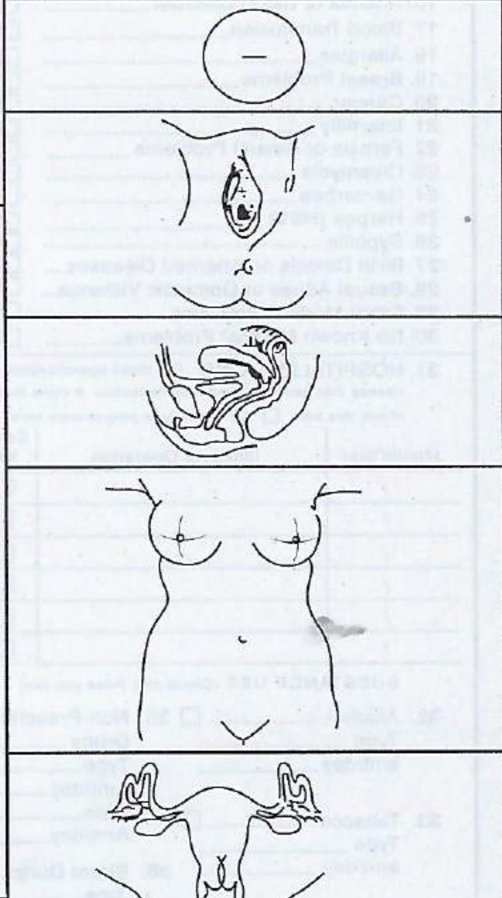
26.Not Performed .... ☐
27.Apparently adequate .... ☐
28.Apparently inadequate .... ☐
29.Excessive caloric intake .... ☐

N.E. = Not Evaluated

Check and detail all positive findings below.
Use system numbers.

LABORATORY PROCEDURES

Test	Date	Result
30. Hgb	/	
31. Hct	/	
32. WBC	/	
33. Differential	/	
34. Pregnancy Test	/	
35. Urinalysis	/	
36. HIV	/	
37. Gonorrhea	/	
38. Chlamydia	/	
39. HSV	/	
40. VDRL Serology	/	
41. Hepatitis	/	
42. Pap Test	/	
43. Wet Mount	/	
44. Culture	/	
45. Stool Occult Blood	/	
46. Blood Glucose	/	
47. Cholesterol	/	
48. Thyroid Screen	/	
49. Biopsy	/	
50. Mammogram	/	
51.	/	
52.	/	
53.		
54.		



Diagnosis and Treatment Plans

Next Appointment: ____ / ____ / ____ Signature: ______________________