Texas Health Women's Care℠

GYNECOLOGY

Name _____ Date _____

Date of Birth _____ Age _____ Why are you here today? _____

How did you hear about us? _____

Drug Allergies _____

OBSTETRICAL HISTORY:

Total number of pregnancies _____

Number of births _____

Number of Miscarriages _____ Abortions _____

Number of Ectopics _____

Any vacuum or forceps-assisted deliveries? Y N

Complications during pregnancy or delivery? Y N

Year	Weeks	Labor Length	Birth Wt LB/OZ	Sex	Type of Delivery (Vaginal or Cesarean Section)

GYNECOLOGICAL HISTORY:

First day of last period? _____

Age at 1st period? _____

Birth control method? _____

Do you have regular cycles? Y N

How long do they last? _____ days

Number of days from start of one cycle to the start of the next? _____ days

Have you gone through menopause? Y N

Age at menopause? _____

Bleeding:

Between periods? Y N

After intercourse? Y N

Heavy cycles? Y N

Pain with periods? Y N

Urination

Loss of urine when you cough? Y N

Difficulty holding your urine? Y N

Get up at night to urinate? Y N

Date of Last PAP Smear _____/_____/_____

Have you ever had an abnormal PAP Y N

If so, when? _____

Any treatment?

Colposcopy Y N

Laser Y N

Cryotherapy Y N

LEEP Y N

Other? _____

Have you ever had an STD?

What was the infection? Please circle

Syphillis Hepa B PID Chlamydia Gonorrhea Herpes Warts

Have you ever had sex? Y N

Are you currently sexually active? Y N

Sexual partners? _____Men _____Women _____Both

Total Number of Partners? _____

PAST MEDICAL HISTORY:

Have you ever had any of the following?

Heart Disease Y N

Kidney Disease / Urinary Infection Y N

Thyroid Disease Y N

Cancer Y N

What kind _____

Asthma / Allergies Y N

High Blood Pressure Y N

Hepatitis A, B, C Y N

Liver Disease Y N

Tuberculosis Y N

Diabetes Y N

Pneumonia Y N

Hospitalizations Y N

Skin Disease Y N

Other _____

GYNECOLOGY

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Name _____ D.O.B. _____

SURGICAL HISTORY:

What kind? _____ Date _____ / _____ /_____
_____ Date _____ / _____ /_____
_____ Date _____ / _____ /_____
_____ Date _____ / _____ /_____

Complications with anesthesia? Y N Blood Transfusions? Y N

MEDICATIONS:

Name _____ Dose _____ How often _____
Name _____ Dose _____ How often _____
Name _____ Dose _____ How often _____
Name _____ Dose _____ How often _____

SOCIAL HISTORY:

Do you smoke? Y N Number of packs per day? _____
Do you drink alcohol? Y N How many per day? _____
Do you use street drugs? Y N What kinds? _____
Marital Status? _____
Occupation? _____

FAMILY HISTORY: *Anyone in the family with the following disease?*

_____ Heart attack Relationship:_____
_____ Stroke Relationship: _____
_____ Breast cancer Relationship: _____
_____ Ovarian Cancer Relationship: _____
_____ High Blood Pressure Relationship: _____
_____ Diabetes Relationship: _____
_____Thyroid Disease Relationship: _____
_____ Colon Disease Relationship: _____
_____ Other Relationship: _____

Name _____ D.O.B. _____

REVIEW OF SYMPTOMS *Have you recently had any of the following?*

Skin
_____ Changes in mole
_____ Rash

Breast
_____ Breast pain
_____ Breast skin change
_____ Nipple discharge

Throat
_____ Difficulty swallowing

Lungs
_____ Shortness of Breath
_____ Coughing up blood
_____ Night sweats
_____ Wheezing

Musculoskeletal
_____ Muscle weakness
_____ Pain in joints

Heart
_____ Chest pain
_____ Palpitations

Neurological
_____ Convulsions/Seizures
_____ Loss of consciousness

Gastrointestinal
_____ Vomiting
_____ Vomiting blood
_____ Bloody stools
_____ Unintended weight loss
_____ Constipation
_____ Diarrhea

Genitourinary
_____ Pain with urination
_____ Urge to urinate all the time
_____ Blood in urine

Endocrine
_____ Always hot or cold
_____ Always tired

Head
_____ Severe headaches
_____ Dizziness
_____ Vision loss

Psychiatric
_____ Depression
_____ Anxiety
_____ Panic Attacks