DuPage Medical Group
Obstetrics & Gynecology

Gynecologic Health History

Name: _____ Date of Birth: _____ Age: _____Religion/Culture:_____
Occupation:_____ Full/Part Time:_____ Education Obtained:_____
Primary Language Spoken: _____ Racial/Ethnic Heritage:_____

Reason for visit:_____

PAST MEDICAL HISTORY (Please check all that apply and give a brief explanation. If it is a family member, please specify relation.**)**

	Patient	Family	Details
1. Headaches or psychiatric disorder	_____	_____	_____
2. Thyroid problem	_____	_____	_____
3. High blood pressure (during or before pregnancy)	_____	_____	_____
4. Heart disorder/disease, heart attack, or stroke	_____	_____	_____
5. Lung disorder	_____	_____	_____
6. Breast problems/breast cancer	_____	_____	_____
7. Liver disorder/disease	_____	_____	_____
8. Stomach, esophagus, bowel, or gallbladder problem	_____	_____	_____
9. Kidney or bladder problem	_____	_____	_____
10. Female problem	_____	_____	_____
11. Sexual problem	_____	_____	_____
12. Blood disorders or history of blood transfusion	_____	_____	_____
13. Diabetes (during or before pregnancy)	_____	_____	_____
14. Cancer (please specify type)	_ _____	_____	_____
15. Birth defects or inherited diseases	_____	_____	_____
16. Allergies or drug sensitivities	_____	_____	_____
17. Other medical problems	_____	_____	_____
18. Smoker	_____	_____	_____
19. Street drug user	_____	_____	_____

Patient's Name _____

PRESENT MEDICATIONS (including vitamins or herbal supplements):

Name of medication	Dosage	Reason for taking

Menstrual History (Please check all that apply):

Age of first period: _____ First day of last menstrual period: _____

Cycle length (number of days between first day of period and first day of next period): _____

Days of flow: _____ Regular or irregular: _____ Heavy flow: Yes____ No ____

Bleeding between cycles: Yes____ No ____ Painful menses: Yes____ No ____

Age of menopause: _____ Hormone replacement use: Past _____ Present _____

Sexual History:

Sexually Active: Yes _____ Never _____ Past _____

Pain with intercourse: Yes _____ No _____

History of sexually transmitted diseases: _____

Sexual Preference: _____

History of sexual/physical abuse: _____

Do you feel safe in your home? Yes _____ No _____

Marital History:

Married _____ Number of Years _____ Number of times married _____

Single _____ Divorced _____ Separated _____ Widowed _____

Who resides in your home with you? _____

Family Planning:	**Past Use**	**Present Use**	**Specific Brand (if available)**
Oral Contraceptive Pills	_____	_____	_____
Contraceptive Patch/Ring	_____	_____	_____
Diaphragm	_____	_____	_____
Condoms	_____	_____	_____
Intrauterine Device	_____	_____	_____
Withdrawal/Rhythm	_____	_____	_____
Sterilization:	Female _____	Male _____	

Other: _____

History of infertility: No _____ Yes _____ Duration _____

Currently being treated for infertility: _____ If yes, briefly describe current treatment: _____

Patient's Name _____

OBSTETRICAL HISTORY

Number of times pregnant _____ Living children _____ Miscarriages _____ Elective abortions _____

Ectopic pregnancy _____ Premature deliveries _____ Adopted children _____ Stepchildren _____

Pregnancy No.	Date of Birth	Weight	Sex	Weeks Of Pregnancy	Vaginal/ C-Sec	Complications
1						
2						
3						
4						
5						
6						
7						

Other hospitalizations and/or surgeries:

Year	Illness or Operation	Complications	
		No	Yes

Date of last Pap smear _____

History of abnormal Pap smear: Yes _____ No _____ If yes, history of colposcopy and/or treatment

for abnormal Pap smear: _____

Last mammogram _____ History of abnormal mammogram: Yes _____ No _____

History of breast ultrasound: Yes _____ No _____

History of breast biopsy or other surgery: Yes _____ No _____

Briefly describe: _____

Last bone density scan _____ Results: Normal _____ Osteopenia _____ Osteoporosis _____

Treatment for bone loss: _____

Family history of colon cancer: Yes ____ No ____ Relationship: _____ Age of onset: _____

Colonoscopy: Year _____ Result _____

Last lipid panel: Year _____ Result _____

Do you have a General Practitioner/Internist? _____ Name: _____

You may use the remainder of this page or the back to include any other pertinent information.

Patient Signature_____
Nurse Reviewer _____Date_____
Physician Reviewer: _____Date_____

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