NEW GYN RECORD

Date ____________________

Name ____________________ Primary Physician ______________

Birthdate __________ Age _____ Referred By ________________

What is the reason for today's visit? ________________

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Physician Comments (Office Use Only)

CC: ____________________

HPI: ____________________

Menstrual History

Age of first period _______ Date of Last Menstrual Period __________

Number of days between start of one period to start of the next _____

Number of days of flow ______ Are periods regular? Yes/No

Amount of flow Light/Medium/Heavy Are periods painful/crampy? Yes/No

Do you have bleeding between periods? Yes/No After intercourse? Yes/No

Gynecology History (Circle all problems in your past or present history)

Abnormal Pap Date _____ Results ______________ Treatment __________

Venereal Warts/Condyloma

Pelvic Inflammatory Disease Chlamydia Gonorrhea Syphillis Herpes

Recurrent Vaginal Infections Recurrent Bladder Infections

Ovarian Cysts Endometriosis Fibroid Uterus Infertility

PMS: Depression Anxiety Fluid Retention Breast Soreness Other ________

Menopausal Symptoms: Hot Flashes Night Sweats Vag Dryness Other _______

Sexual Problems: Decreased Sex Drive Painful Sex Other _____

Breast Problems: History of Cancer Discharge Abnormal Mammogram

Past Biopsy Date _______ Results _________ Implants Reduction

Birth Control Method ____________________

Medical History (Check all problems in your past or present history)

Chicken Pox	___	Chronic Lung Disease	___	Tuberculosis	___
Asthma	___	Heart Disease	___	Hypertension	___
High Cholesterol	___	Mitral Valve Prolapse	___	Heart Murmer	___
Stroke	___	Headaches	___	Seizures	___
Kidney Stones	___	Kidney Infections	___	Ulcers/Reflux	___
Liver Disease	___	Hepatitis/Jaundice	___	Irritable Bowel	___
Gallstones	___	Diabetes	___	Thyroid Disease	___
Arthritis	___	Anemia	___	Blood Transfusion	___
Cancer	___	Glaucoma	___	Hearing Problem	___
Major Accident	___	Depression/Anxiety	___	Osteoporosis	___

Review of Systems (Circle all Current Problems)

1. Constitutional: Weight loss, Weight Gain, Fevers, Fatigue
2. Eyes: Contacts/Glasses, Double Vision, Spots Before Eyes, Tunnel Vision
3. ENT: Ear aches/Ringing, Sinus Problems, Sore Throat/Mouth, Dental Problem
4. CV: Palpitations, Chest Pain, Difficulty Breathing, Leg Swelling
5. Respiratory: Wheezing, Spitting up Blood, Shortness of Breath, Chronic Cough
6. GI: Diarrhea, Bloody, Nausea/Vomiting, Constipation, Hemorroids, Incontinence
7. Urinary: Blood, Pain, Urgency, Frequency, Incontinence, Incomplete emptying
8. Musculoskeletal: Muscle Weakness, Joint Pains, Low Back Pain
9. Skin/Breast: Breast Pain, Discharge, Masses, Rash, Ulcers, Acne, Facial Hair
10. Neurological: Dizziness, Seizures, Numbness, Trouble Walking
11. Psychiatric: Depression, Crying, PMS, Sleep Disorder, Eating Disorder
12. Endocrine: Dry Skin, Abnormal Thirst, Hair Loss, Vocal Changes
13. Hematologic/Lymphatic: Bruising, Enlarged Lymph Nodes, Abnormal bleeding
14. Allergy/Immunologic: Environmental Allergies/Food Allergies/Immune problem

Date ______________
Name ____________________________

NEW GYN RECORD

Obstetrical History

List all pregnancies including live births, stillbirths, miscarriages, abortions and tubal pregnancies

Date	Hospital	Length Pregnancy	Duration Labor	Type Delivery	Problems

Surgery/Hospitalizations

Year	Operation/Medical Problem

Medications (Including Vitamins)

Medication	Dosage

Allergies: Medication/Type Reaction

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Social History

Occupation ________________
Marital Status Single/Married/Widow/Divorced
Sexual Preference Heterosexual/Homosexual/Bisexual
Do you Exercise? Yes/No Type of Exercise_____**Times/Week** ______
Do you Smoke? Yes/No Number cigarettes per day ______
Do you drink alcohol? Yes/No Number per Week ______
Do you use recreational Drugs? Yes/No Type of Drugs ______
Do you Always wear your Seatbelt in the car? Yes/No
Do you have problems with Verbal/Physical Abuse? Yes/No
Do you follow a special diet? Yes/No Type of Diet ________

Screening Tests/ Vaccine (List Most Recent Date)

Pap Smear ______________ **Normal/Abnl**
Mammogram ______________ **Normal/Abnl**
Cholesterol ______________ **Normal/Abnl**
Sigmoid/Colonoscopy ________ **Normal/Abnl**
EKG/Stress Test ____________ **Normal/Abnl**
Bone Density Test __________ **Normal/Abnl**
TB Skin Test ______________ **Normal/Abnl**
Rubella Immunity ___________ **Yes/No**
Tetanus Booster Received ______________
Flu Shot Received ________________
Pneumonia Vaccine Received ______________

Family History

Please indicate which family members have the following conditions (Past or Present)

Heart Disease ____________ **Ovarian Cancer** ____________ **Birth Defects** ____________
Hypertension ____________ **Breast Cancer** ____________ **Osteoporosis** ____________
High Cholesterol ____________ **Uterine Cancer** ____________
Diabetes ____________ **Colon Cancer** ____________

Mom: Name ______________ **Alive/Deceased Age** ______ **Health Issues** ______________
Dad: Name ______________ **Alive/Deceased Age** ______ **Health Issues** ______________
Siblings 1. Name __________ **Alive/Deceased Age** ______ **Health Issues** ______________
2. Name __________ **Alive/Deceased Age** ______ **Health Issues** ______________
3. Name __________ **Alive/Deceased Age** ______ **Health Issues** ______________
4. Name __________ **Alive/Deceased Age** ______ **Health Issues** ______________
5. Name __________ **Alive/Deceased Age** ______ **Health Issues** ______________

Please List Any Additional Issues or Comments to Address

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