The New School

GYNECOLOGICAL HISTORY FORM

Student Health Services

Name _____ _____ Date _____/_____/_____
(last name) (first name)

Telephone: Day_____ Night_____ ID#_____

GYNECOLOGICAL AND OBSTETRICAL HISTORY

First day of your last period _____/_____/_____ Age at first menstruation_____ How long does your period last?_____

How often do your periods occur? (e.g., monthly, every 6 weeks) _____

On the heaviest day, how many pads or tampons do you use?_____ Any cramps?_____

What treatment do you use for cramps?_____

Any PMS symptoms?_____ Describe:_____

Do you spot or bleed between periods or after intercourse?_____ Describe_____

Ever Pregnant?_____ If yes: Date(s) _____ Outcome(s) _____

Is this your first GYN exam?_____ Any history of STDs?_____ If yes, which one(s)? _____

Date of last Pap Smear_____ Have you ever had an abnormal Pap Smear?_____ If so, when?_____

Any breast problems?_____ Do you examine your breasts regularly?_____

SEXUAL HISTORY

Have you had sex with (Circle): men, women, neither, or both? How old were you when you first had sex?_____

Have you had more than one partner in the last year?_____ Do you have any pain with intercourse?_____

If you use contraception, what form(s) do you use? _____ Do you wish to continue with this method?_____

Have you ever experienced sexual assault or incest?_____ Is there violence in any of your relationships?_____

MEDICAL HISTORY

Do you have (or have you had) any medical problems? (For example: asthma, diabetes, high blood pressure, heart disease, seizure disorder, migraine headaches, gall bladder disease, clotting disorder, abnormal cholesterol, thyroid problems, urinary tract problems) If yes, circle and describe:_____

Are you taking any medications?_____ Which ones and how often?_____

Any vitamins?_____ Which ones and how often?_____

SURGICAL HISTORY

Have you ever had any surgery? (Including oral surgery, tonsils, abdominal surgery. etc.)_____

If yes: Date_____ Type_____ Complications_____

Date_____ Type_____ Complications_____

Date_____ Type_____ Complications_____

FAMILY HISTORY

Do your parents or siblings have any of the following? (Check) ☐High cholesterol ☐Stroke ☐Blood clots ☐Diabetes ☐Breast cancer ☐Liver cancer ☐Heart disease (heart attack) ☐High blood pressure ☐Other_____

Do any women in you family have a history of: ☐ breast cancer ☐ uterine cancer ☐ ovarian cancer

If yes, who?_____

SOCIAL HISTORY

Do you smoke tobacco?_____ If yes, how much per day?_____ How much alcohol do you drink each week? _____

Do you use 'recreational' drugs?_____ If yes, which ones?_____

ALLERGIES

Are you allergic to any medicines?_____ Which ones?_____

What is your reaction?_____

CONCERNS

Do you have any concerns about (Circle): AIDS, safer sex, sexual assault, breast self-exam, contraception or other health topics?

_____

_____

Clinician's Notes: See other side