

# GYNECOLOGY & INFERTILITY

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## GYNECOLOGICAL HISTORY

Last Normal Menstrual Period (1st day) \_\_\_\_\_

Age Periods Began \_\_\_\_\_

Length of Periods \_\_\_\_\_

Length of Cycle \_\_\_\_\_

Present Method of Birth Control \_\_\_\_\_

Have you ever used IUD or BC Pill \_\_\_\_\_

Last Pap Smear Date \_\_\_\_\_

## PREGNANCY HISTORY

Number of Abortions \_\_\_\_\_ Years \_\_\_\_\_

Number of Miscarriages \_\_\_\_\_ Years \_\_\_\_\_

Number of Children \_\_\_\_\_ Year(s) \_\_\_\_\_

Type of Delivery \_\_\_\_\_

Complications \_\_\_\_\_

Varicose Veins \_\_\_\_\_

Thyroid Disease \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Hepatitis/Liver Disease \_\_\_\_\_

Gallbladder Disease \_\_\_\_\_

Anorexia/Bulemia/Eating Disorder \_\_\_\_\_

Anemia/Blood Disorder \_\_\_\_\_

Easy Bruising/Bleeding Problems \_\_\_\_\_

Cancer \_\_\_\_\_

Collagen Vascular Disease (Lupus) \_\_\_\_\_

Arthritis/Back Problems \_\_\_\_\_

Previous Bone Fractures \_\_\_\_\_

Urinary/Bowel Problems-Type/Frequency \_\_\_\_\_

## DO YOU HAVE A HISTORY OF: (Include Dates)

Abnormal/Irregular Periods \_\_\_\_\_

Abnormal Pap Smear \_\_\_\_\_

Colposcope/Cryosurgery/Laser Surgery \_\_\_\_\_

\_\_\_\_\_

Genital Warts/Herpes/Chlamydia/Gonorrhea \_\_\_\_\_

\_\_\_\_\_

Pelvic Inflammatory Disease \_\_\_\_\_

Infertility/Amenorrhea \_\_\_\_\_

Endometriosis \_\_\_\_\_

DES Exposure \_\_\_\_\_

Ovarian Cysts \_\_\_\_\_

Ovarian Cancer \_\_\_\_\_

Uterine Cancer \_\_\_\_\_

Fibroids \_\_\_\_\_

Breast Disease \_\_\_\_\_

Breast Surgery \_\_\_\_\_

Breast Discharge \_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_

Mammogram \_\_\_\_\_

Past Surgical History \_\_\_\_\_

\_\_\_\_\_

## DO YOU EXPERIENCE:

Hot Flashes \_\_\_\_\_ Vaginal Dryness \_\_\_\_\_

Irregular Vaginal Bleeding \_\_\_\_\_

## MEDICAL HISTORY:

Blood Transfusion \_\_\_\_\_

Heart Disease/Murmur \_\_\_\_\_

High Blood Pressure/Stroke \_\_\_\_\_

Phlebitis/Pulmonary Embolism \_\_\_\_\_

Sexual Problems \_\_\_\_\_

Have you taken Heparin, Steroids, Thyroid

Medications \_\_\_\_\_

Last Cholesterol \_\_\_\_\_

Last Fasting Blood Sugar \_\_\_\_\_

Last Sigmoidoscopy \_\_\_\_\_

Last Bone Density \_\_\_\_\_

Last Immunization for Tetanus \_\_\_\_\_

Have you been immunized for Hepatitis B \_\_\_\_\_

Other Immunizations lately? \_\_\_\_\_

## PERSONAL HISTORY

Allergies to Medications \_\_\_\_\_

Other Allergies \_\_\_\_\_

Current Medicines, Hormones, Vitamins, Herbs

\_\_\_\_\_

Caffeine (Cups of coffee, tea, soda/day) \_\_\_\_\_

#Cigarettes/day \_\_\_\_\_ Past Cigarette Use \_\_\_\_\_

#Years \_\_\_\_\_ Current Alcohol Intake \_\_\_\_\_

Exercise: Type \_\_\_\_\_

Do you perform breast exam? \_\_\_\_\_

## FAMILY HISTORY:

Breast Cancer \_\_\_\_\_ Ovarian \_\_\_\_\_

Uterine \_\_\_\_\_ Colon \_\_\_\_\_

Prostate \_\_\_\_\_ Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_

High Cholesterol \_\_\_\_\_

Osteoporosis \_\_\_\_\_

Premature Menopause \_\_\_\_\_

Did your mother have menopausal problems? \_\_\_\_\_

Alzheimer's Disease \_\_\_\_\_

Other \_\_\_\_\_