

Birth & Women's Health Center
2595 N. Wyatt Dr., Tucson, AZ 85712

GYNECOLOGICAL MEDICAL and SURGICAL HISTORY

MEDICAL HISTORY – List past illnesses	SURGERIES – all operations	SOCIAL
1.	1.	Do you work outside the home?
2.	2	List members of your household?
3.	3	
4.	4	

Please circle YES or NO to all of the following:

PAST ILLNESSES	MENSTRUAL HISTORY	REVIEW OF SYSTEMS
Childhood diseases – circle: Measles, Mumps, German Measles, Chicken Pox, Scarlet Fever, Whooping Cough, Rheumatic Fever, Polio	Age of 1 st period? No. days between periods: No. days of flow: Bleeding between periods? Yes No	EYES, EARS, NOSE & THROAT
Pneumonia Yes No	Flow: Heavy Moderate Light Pain: Severe Moderate Light	Dizziness Yes No Double vision Yes No Glasses/contact lens Yes No
Thyroid Disease Yes No	Date of last PAP smear?	Ear Infections Yes No Hearing Loss Yes No
Heart Disease Yes No	Ever had an abnormal PAP? Yes No	Nose bleeds Yes No Bleeding gums Yes No
High Blood Pressure Yes No	If yes, explain:	Frequent sore throat Yes No
Asthma Yes No	PREGNANCIES	HEART
Diabetes Yes No	Number of pregnancies:	Chest pain Yes No
Cancer Yes No	Number of living children:	Swelling of ankles Yes No
Epilepsy (seizures) Yes No	Any complications?	Can you climb stairs easily? Yes No
Tuberculosis Yes No	Age of children:	LUNGS
Valley Fever Yes No	SEXUAL HISTORY	Chronic cough Yes No
Bone or joint disease Yes No	Have you ever had sex? Yes No	Cough with blood Yes No
Kidney or bladder infections Yes No	Have you had sex with: Men Women Both	Pain with breathing Yes No
Anemia Yes No	Do you have a current partner? Yes No	GASTROINTESTINAL
Jaundice Yes No	If yes, is this partner a man or woman?	Hard to swallow Yes No
Eating Disorder Yes No	How many partners have you had since becoming sexually active? _____	Abdominal pain Yes No
Nervous breakdown Yes No	How many in the last year? _____	Frequent nausea/vomiting Yes No
Hives or Eczema Yes No	Have you ever had a sexually transmitted infection?	Rectal bleeding Yes No
ALLERGIES – Please list	Circle all that apply:	Blood in stool Yes No
Medications:	Chlamydia Herpes Gonorrhea	KIDNEY/BLADDER
Environmental:	Hepatitis Syphilis Trichomoniasis	Kidney pain Yes No
DRUGS	HIV/AIDS Genital Warts/HPV	Burning/frequency on urination Yes No
Current prescription medications:	Other:	Poor control of urination Yes No
Over the counter medications:	Method of birth control?	VASCULAR
Herbs:	SOCIAL HISTORY	Phlebitis (blood clots) Yes No
IMMUNIZATIONS	Do you drink alcohol? Yes No	Varicose veins Yes No
Date of last Tetanus booster:	How much/how often?	NEUROLOGICAL
Influenza vaccine: Yes No	Do you ever feel that you have a problem with alcohol use? Yes No	Frequent headaches Yes No
Pneumonia vaccine Yes No	Has anyone said you should cut down? Yes No	Muscle weakness or paralysis Yes No
FAMILY HISTORY	Do you need a drink to get going in the morning? Yes No	Loss of consciousness Yes No
List parents or siblings having:	Do you smoke tobacco? Yes No	BLOOD/GLANDS
Cancer	If yes, how much? _____	Do you bleed easily? Yes No
Tuberculosis	Are you interested in quitting? Yes No	Do you have any enlarged glands in your neck, under arms, or groin? Yes No
Diabetes	Do you use recreational drugs such as: ecstasy, Marijuana, cocaine, crystal meth? Yes No	If yes, where?
High Blood Pressure	If yes, which drug and how often: _____	UTERUS/VAGINA
Heart Disease	Do you feel that you have a problem? Yes No	Excessive bleeding Yes No
Inherited disorders	Does anyone close to you have a problem – Y N	Vaginal discharge/itching Yes No
Blood Transfusion: Yes No		Contact bleeding Yes No
If yes, reaction?		Uterine abnormality Yes No
DOMESTIC VIOLENCE		

Have you ever been emotionally abused or hit, slapped, kicked, physically hurt by someone important to you? _____
 As a child or adult, has anyone touched you or forced into sexual activity in which you did not want to participate? _____
 Are you are your children afraid of your partner or someone important to you? _____
 If you have answered yes to any questions, would you like to talk to us about this? _____
 If you would like to talk to us, do you prefer to discuss it without family members present? _____

PATIENT NAME: _____ **CLINICIAN** _____ **DATE:** _____