COMPASSION WOMEN'S CLINIC
GYNECOLOGIC HISTORY INFORMATION SHEET

Today's date_____

Name_____

Age_____ **Date of birth**_____

Primary Care Doctor:

_____

Any concerns/issues you would like to discuss today?

_____

OBSTETRIC HISTORY- ☐No changes

Pregnancies_____ Deliveries_____

Vaginal=_____ Miscarriages_____

Cesarean=_____ Elective Abortions_____

PAST MEDICAL HISTORY - ☐No changes

PAST SURGICAL HISTORY- ☐No changes

MEDICATIONS ☐No changes

Contraception= _____

Other= _____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES to any medicines ☐No changes

List: _____

MENOPAUSE (if applicable)-

When did this begin?	
Which hormone replacement therapy are you taking? ☐ N/A Any other hormones in the past?	

What symptoms are you having? Please circle

Hot flashes	Vaginal dryness	Night sweats
Vaginal bleeding	Low libido	Insomnia
Mood changes		

GYNECOLOGIC HISTORY-

First day of last menstrual period?	
Age at 1st period	
# of days between periods (from 1st day of period to 1st day of next period)	
Length of period (# of days of bleeding)	
Heavy bleeding?	Y / N
Cramps?	Y / N

Number of sexual partners in last year	
Sexual Preference: Male / Female / Both	
Are you currently sexually active?	Y / N
Have you had any sexually transmitted diseases? If yes, which ones?_____	Y / N
Would you like to be tested today?	

When was your last pap smear?	
Any history of abnormal pap smears? When was this? What treatment was performed?	Y / N
Do you do self-breast exams?	Y / N

Any history of sexual abuse or domestic violence?	Y / N
Would you like to talk about this today?	Y / N

SOCIAL HISTORY-

Marital status	Single / Married / Separated / Divorced		
Smoke?	Y / N	How many packs a day?	
Drink alcohol?	Y / N	How many drinks a week?	
Drug Use?	Y / N	Which drugs?	
Do you exercise?	Y / N	What kind and how often?	
Completed HPV vaccine? (26 or younger)	Y / N	Would you like more information?	

FAMILY HISTORY- Please circle all that apply

Breast cancer	Uterine cancer	Ovarian caner
Colon cancer	Stroke	High blood pressure
Heart disease	Blood clots	Diabetes
Osteoporosis	Birth defects	Other:

PREVENTATIVE ASSESSMENT-

	Last Time Performed
Cholesterol (>45, q 5 yr)	
Diabetes (>45, q 3 yr)	
Mammogram (>40, q 1-2 yr)	
Colonoscopy (> 50, q 10 yr)	
Bone density (>65, q 2 yr)	
Thyroid (>45, q 5 yr)	

REVIEW OF SYSTEMS- Please circle any that apply

☐ **NONE OF THE BELOW**

Fever	Fatigue	Hair loss
Chest pain	Cough	Shortness of breath
Palpitations	Feeling hot/cold	
Breast pain	Breast lump	Nipple discharge
Diarrhea	Constipation	Blood in stools
Weight loss/gain	Change in height	Blood in urine
Urination Pain	Frequent urination	
Urge to urinate	Loss of urine	