Gynecology & Gynecologic Oncology
HEALTH HISTORY FORM
CONFIDENTIAL

Patient Label

Primary care provider: _____

Referring provider: _____

Gynecologic History – *All patients to complete shaded area*

Age?	Weight?
Reason for Visit?	
First day of last menstrual period?	
Have you had a new partner since your last visit? ☐ YES ☐ NO	

New patients only, unless changes have occurred

General:	***Sexual Health:***
Age at menarche (first period)?	Are you sexually active?
Date of last pap smear?	Birth control method (used by you or a partner)?
If you are menopausal:	Pain or problems with sex?
Age at menopause?	***Pregnancy History:***
Any vaginal bleeding since menopause?	# pregnancies?
Hormone Replacement Therapy? ☐ Past ☐ Present	# full terms birth: Vaginal? Cesarean section?
If you are menstruating:	# spontaneous or therapeutic abortions?
# of days between periods?	# ectopic pregnancies?
# days bleeding?	Future pregnancy desired? ☐ Yes ☐ No
Problems with menses or abnormal bleeding/discharge?	

Check any of the items that apply to your gynecologic history:

☐ Abnormal Pap **date:**	☐ Treatment for cervical dysplasia **date:**	☐ History of gyn cancer **date:**
☐ Endometriosis **date:**	☐ Fibroids **date:**	☐ Headaches
☐ Gonorrhea **date:**	☐ Genital Warts **date:**	☐ Herpes **date:**
☐ Chlamydia **date:**	☐ HPV vaccine **date:**	☐ Osteoporosis **date:**
☐ Infertility **date:**	☐ Prior blood transfusion **date:**	☐ IUD use **date:**
☐ Hysterectomy **date:**	☐ Bladder surgery/Urine loss **date:**	☐ Other GYN surgery **date:**

Date of last:

Mammogram?
Pap Smear?
Bone Mineral Density (DEXA)?
Colonoscopy/Sigmoidoscopy?

In office use only:

BP_____ Pulse _____ Temp _____ Height _____