Gynecology Health History Form

Date: ____/_____/_____ Patient's Name: _____________________ Referred By: __________________ Age:____

CC:

Past Medical History	***Patient***	***Family***
1. Headaches/Neurological Disorder		
2. Thyroid Disease		
3. Lung Disorder		
4. Heart Condition		
5. High Blood Pressure		
6. Breast Disease/Cancer		
7. Liver Disease/Hepatitis		
8. Stomach/Bowel/Gallbladder Problems		
9. Kidney/Bladder Problems		
10. Anemia/Blood Disorders/Transfusions		
11. Diabetes		
12. Birth Defects/Congenital Disorders		
13. Female Cancers (Ovarian, Uterine, Cervix)		

Past Surgical History	***Year***
1	
2	
3	
4	

Medications	***Drug Allergies/NKDA***
1	1
2	2
3	3
4	4
5	5

***Please attach list for more than 5 medications*

***Obstetrical History:* G P**

Year	SVD/C.Sec/Miscarriage/Ab./Ectopic	Weeks	Complications
1			
2			
3			
4			

Gynecologic History

LMP:	Birth Control Method:	Last Pap Smear:
Cycle Length:	Sexually Active:	Last MMG:
Duration:	Dyspareunia:	Abn. Pap/MMG:
Menarche:	STD's:	Dexa Scan:
Dysmenorrhea:	Colonoscopy:	Incontinence:

Social History

Married/Single:	Tobacco/Alcohol/Drugs:
Employed:	Domestic/Physical/Sexual Abuse:
ROSS:	

Review of Symptoms (ROS)

Problem Pertinent ROS = Positive & pertinent negative responses relaed to problem

Gynecology Health History Form

Extended ROS = Positive & pertinent negative responses for 2-9 systems
Complete ROS = Positive & pertinent responses for at least 10 systems
☐ No changes since ______ / _______ /________

1. Constitutional	☐Negative ☐Other	☐Weight Loss	☐Weight Gain	☐ Fever	☐ Fatigue
2. Eyes	☐Negative ☐Other	☐Vision Change	☐Glasses/Contacts		
3. ENT/Mouth	☐Negative ☐Other	☐Ulcers	☐Sinusitis	☐ Tinnitus	☐ Headache
4. Cardiovascular	☐Negative ☐Other	☐Orthopnea	☐Chest Pain	☐ DOE	☐ Edema
5. Respiratory	☐Negative ☐Other	☐Wheezing	☐Hemoptysis	☐ SOB	☐ Cough
6. Gastrointestinal	☐Negative ☐ Flatulence	☐Diarrhea ☐Pain	☐Bloody Stool ☐Other	☐ N/V	☐ Constipation
7. Genitourinary	☐Negative ☐Incomplete Emptying ☐Other	☐Hematuria	☐Dysuria ☐Incontinent	☐ Urgency ☐Anal Bleeding	☐ Frequency ☐ Dyspareunia
8. Muskuloskeletal	☐Negative ☐Other	☐Muscle Weakenss			
9. Skin/Breast	☐Negative ☐Other	☐Mastalgia	☐Discharge	☐ Masses	☐ Rash
10. Neurological	☐Negative ☐Other	☐Syncope ☐Trouble Walking	☐Seizures	☐ Numbness	
11. Psychiatric	☐Negative ☐Other	☐Depression	☐Crying		
12. Endocrine	☐Negative ☐Other	☐Diabetes	☐Hypothyroid	☐ Hyperthyroid	☐ Hot Flashes
13. Hemat/Lymph	☐Negative ☐Other	☐Bruises	☐Bleeding	☐ Adenopathy	
14. Allergic / Immuno: (See First Page)					

Level of History	***Requirements for Levels of History***			
	CC	**HPI**	**PFSH**	**ROS**
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	N/A	Problem Pertinent
Detailed	Required	Extended	Pertinent	Extended
Comprehensive	Required	Extended	Complete	Complete