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GYN EXAM FORM

Date of exam: _____

Name: _____ DOB: _____SS#: _____
Address: _____ Phone: _____ Age: _____

Family History – Has anyone in your family had trouble with the following? Include mother (M), father (F), brother (B), sister (S), aunt (A), uncle(U), grandmother (GM), grandfather (GF).

	NO	Not Sure	YES	WHO
Anemia	____	____	_____	_____
Bleeding Problem	____	____	_____	_____
Breast Disease	____	____	_____	_____
Cancer	____	____	_____	_____
Gyn Cancer	____	____	_____	_____

	NO	Not Sure	YES	WHO
Diabetes	____	____	_____	_____
High Blood Pressure	____	____	_____	_____
Stroke	____	____	_____	_____
Heart Attack (before 50)	____	____	_____	_____
Other Hereditary Disease	_____			

MEDICAL HISTORY – Information about you. Check all that applies

	NO	YES	NOW
Anemia	___	___	___
Blurred vision	___	___	___
Headaches	___	___	___
Migraines	___	___	___
Stroke	___	___	___
Severe depression	___	___	___
Severe mood swings	___	___	___
Psychiatric problems	___	___	___
Diabetes	___	___	___
Cancer	___	___	___

	NO	YES	NOW
Lung disease	___	___	___
Liver disease	___	___	___
Thyroid problem	___	___	___
Breast surgery	___	___	___
High blood pressure	___	___	___
Chest pain	___	___	___
Shortness of breath	___	___	___
Heart murmur	___	___	___
Heart disease	___	___	___
Asthma	___	___	___

	NO	YES	NOW
Varicose veins	___	___	___
Blood clots	___	___	___
Redness/pain in leg	___	___	___
Gallbladder problems	___	___	___
Urinary tract infections	___	___	___
Smoking	___	___	___
Alcohol use	___	___	___
Recreational drug use	___	___	___
Eating disorder	___	___	___
Regular exercise	___	___	___

GYN HISTORY

	NO	YES	When
Pelvic tumors/fibroids	___	___	_____
Pelvic infections	___	___	_____
Pelvic surgery	___	___	_____
Abnormal PAP	___	___	_____
Vaginal infection	___	___	_____

	NO	YES	When
Unusual vaginal bleeding	___	___	_____
Unusual vaginal discharge	___	___	_____
Pregnancy	___	___	_____
Abortions	___	___	_____
Hepatitis B vaccine	___	___	1 ___2___3___

First day of last menstrual period _____ Was last period normal _____Last PAP date _____Result _____
Period started at age _____ Occur every _____ days. Duration _____ days.
Periods are: __regular __irregular __light __moderate __heavy __painful. Do you do a self-breast exam monthly __YES __NO
Have you ever had sexual intercourse __YES __NO If yes, __vaginal __anal __oral Do you/have you had sex with __men __women __both
Number of sexual partners in the past 2 years _____ Length of time with current/most recent sexual partner? _____
Condom protection always __YES __NO Have any of your sexual partners been in a high risk category for HIV/AIDS? __YES __NO
____More than one partner? ___Bisexual? ___Used Drugs? ___
Have you had unprotected sex since your last menstrual period? __YES __NO Any missed birth control pills? __YES __NO
What are you doing to protect yourself from HIV/AIDS, Hepatitis B or C, and all STD'S? _____
How many times have you used condoms in the last 10 acts of intercourse? _____
Have you ever had any of the following: **Chlamydia**: __YES __NO **Genital warts**: ___YES __NO **Gonorrhea**: ___YES __NO Herpes: __YES __NO
Hepatitis B: ___YES __NO

Any other pertinent history or concern:
_____
_____
_____

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