

HISTORY SHEET

Date _____

Name _____ Age _____ Birth date _____

What brings you to our office today?: _____

MENSTRUAL HISTORY

Date last period started? _____ Do you have bleeding between periods? _____

How many days between periods? _____ How many days do you bleed? _____

Do you have pain with periods? _____

If your problem is lack of periods or irregular periods, please describe under "COMMENTS".

COMMENTS: _____

PAP SMEAR HISTORY

Date of last Pap: _____ Normal Abnormal Have you ever had an abnormal pap smear? YES NO

OBSTETRICAL HISTORY

Pregnancies _____ Terminations _____ Miscarriages _____ Living Children _____

Date of Delivery _____ Months Pregnant _____ Complications _____ Birth Weight _____ Other Complications _____

GYNECOLOGIC HISTORY

YES NO

Have you ever had pelvic surgery? If so, please list under "COMMENTS" include place of surgery and date.

Have you ever had gonorrhea, syphilis, chlamydia or herpes?

Have you ever had a vaginal discharge or infections?

Do you have bleeding with intercourse?

Have you ever had a tubal infection?

COMMENTS: _____

MAMMOGRAM HISTORY

Have you had a mammogram? YES NO Date of mammogram: _____ Normal Abnormal

COMMENTS: _____

CONTRACEPTION HISTORY

Present Method: _____ Past Method: _____

GENERAL MEDICAL

YES NO Childhood diseases? If yes, please list: _____

YES NO Adult diseases? If yes, please list: _____

YES NO Surgery (other than pelvic)? If yes, please list: _____

YES NO Drug allergies? If yes, please list: _____

Medications or drugs you are currently taking?: _____

Vitamin pills (what and how much): _____

YES NO Do you smoke cigarettes? If yes, amount? _____ For how long? _____

YES NO Do you drink alcohol? If yes, how much? _____

YES NO Do you drink coffee or tea? If yes, how much? _____

YES NO Has your weight changed in the last year? If yes, how much? _____

DO YOU HAVE ANY ABNORMALITIES OF:

- | | | |
|------------------------------|-----------------------------|--|
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Head, eyes, ears, nose, throat (headaches, difficulties with vision, "fits", convulsions, etc) |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing (cough, wheezing, TB, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations, chest pains, shortness of breath, history of heart disease or murmur. |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge (bloody, watery or milky), breast pain or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea, vomiting, jaundice, bloody bowel movements, diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney or bladder infection, stones, blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, bone or joint pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin problems, including excessive hair, loss of hair, change in color or acne |
| <input type="checkbox"/> | <input type="checkbox"/> | "Nervous problems" (depression, suicide attempts, anxiety or psychiatric consultation) |

If you have answered yes to any of the above, please explain: _____

FAMILY HISTORY

	Age, or age at death	Illnesses or cause of death
Mother	_____	_____
Father	_____	_____
Sisters	_____	_____
Brothers	_____	_____

Is there a family history of breast cancer? _____