GYN/OB PATIENT HEALTH HISTORY UPDATE

Patient Name:	Date of Birth:
Reason for visit:	Today's Date:

SEXUAL HISTORY

Sexual activity:	☐ Yes ☐ No ☐ Not currently Age at first contact: _____ Number of partners in lifetime: _____ Partners: ☐ Male ☐ Female ☐ Both
Current Birth Control:	☐ Condom ☐ Pill ☐ IUD ☐ Patch ☐ Injection ☐ Diaphragm ☐ Tubal ligation ☐ Implant ☐ Ring ☐ Abstinence ☐ Post-menopausal ☐ Spermicide ☐ Other: _____

Do you have a history of sexually transmitted infections? ☐ Yes ☐ No

☐ HPV (human papilloma virus) ☐ HSV (herpes simplex virus) ☐ Pelvic inflammatory disease

☐ HIV (human immunodefiency virus) ☐ Genital warts/condyloma ☐ Gonorrhea

☐ Chlamydia ☐ Trichomonias ☐ Syphilis

OBSTETRIC HISTORY

How many times total have you been pregnant? _____

How many miscarriages/abortions? _____

How many full-term deliveries? _____

How many preterm deliveries? _____

How many live children do you have? _____

Have you had difficulty becoming pregnant? ☐ Yes ☐ No

PLEASE LIST ALL PREGNANCIES

Date	Weeks	Vaginal/C-section/VBAC	Weight	Male/Female	Preterm labor	Comments
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	
					Yes/No	

GYNECOLOGICAL HISTORY

Menarche: (age at which you first started your period)? _____

Menstruation:

First day of your last period? _____

How long between periods? (first day of last to first day of next, number of days) _____

How long does your period last? (number of days) _____

How many pads or tampons do you use per day? _____

Painful periods? ☐ Severe ☐ Moderate ☐ Minimal ☐ None

Quantity of bleeding? ☐ Heavy ☐ Medium ☐ Light

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PCC213 SP/PMR Rev 01/08/2020

GYN/OB PATIENT HEALTH HISTORY UPDATE

GYNECOLOGICAL HISTORY continued...

Premenstrual symptoms:

☐ Mood swings ☐ Lethargy ☐ Irritability ☐ Headache ☐ Depression ☐ Libido change

☐ Breast discomfort ☐ Bowel changes ☐ Bloating ☐ Anxiety ☐ Ankle swelling ☐ Other: _____

Menopausal: ☐ Yes ☐ No

Age began menopause _____ Symptoms: _____

PREVENTIVE HEALTH HISTORY

Colonoscopy: Date: _____

Mammogram: Date: _____

Bone density scan: Date: _____

Tetanus shot: Date: _____

Pap smear: Date: _____ Abnormal: ☐ Yes ☐ No Date: _____

Treatment: ☐ Yes ☐ No

LEEP: Date: _____

Cryotherapy: Date: _____

Cone biopsy: Date: _____

Colposcopy: Date: _____

I have carefully reviewed this questionnaire and completed it to the best of my knowledge.

_____ _____

Signature of patient, parent or legal guardian (circle one) Date / Time

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