

Gynecology Update Form

Name _____ Age _____ Date of Birth _____ Date ____ / ____ / ____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? YES NO

If YES, please describe _____

PAST SURGICAL HISTORY:

Have you had any recent SURGERY? YES NO

If YES, please describe _____

MEDICATIONS:

Please list all your PRESCRIBED MEDICATIONS:

Medication	Dose	Medication	Dose
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Please list all the OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO

If YES, please give name of medication and reaction _____

PREVENTATIVE HEALTH MAINTENANCE:

When was your last MAMMOGRAM? ____ / ____ / ____ NEVER

When was your last BONE DENSITY STUDY? ____ / ____ / ____ NEVER

When was your last COLONOSCOPY? ____ / ____ / ____ NEVER

If you are over 65, have you ever received a pneumonia vaccine? YES NO N/A

Did you receive a flu vaccine during the most recent flu season (September-February)? YES NO



FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? YES NO

If YES, please note changes:

M= Mother **F=** Father **S=** Sister **B=** Brother **MGM=** Maternal grandmother **MGF=** Maternal grandfather
PGM= Paternal grandmother **PGF=** Paternal grandfather

- 1. High blood pressure M F S B MGM MGF PGM PGF
- 2. Diabetes M F S B MGM MGF PGM PGF
- 3. Heart disease M F S B MGM MGF PGM PGF
- 4. Breast cancer M F S B MGM MGF PGM PGF
- 5. Ovarian cancer M F S B MGM MGF PGM PGF
- 6. Colon cancer M F S B MGM MGF PGM PGF
- 7. Thyroid disorder M F S B MGM MGF PGM PGF
- 8. Osteoporosis M F S B MGM MGF PGM PGF
- 9. Blood clotting disorder M F S B MGM MGF PGM PGF
- 10. Deep venous thrombosis
(DVT – blood clot deep in leg) M F S B MGM MGF PGM PGF
- 11. Autoimmune disorders
(such as lupus, rheumatoid arthritis, etc) M F S B MGM MGF PGM PGF
- 12. Other _____

MENSTRUAL HISTORY:

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? _____
- Are your periods REGULAR or IRREGULAR?
- How many DAYS are there BETWEEN your cycles? _____
- How many DAYS do your periods LAST? _____
- Are your periods: LIGHT MODERATE HEAVY
- Do you frequently SPOT between periods? YES NO
- Do you pass large CLOTS with your periods? YES NO _____
- Describe your CRAMPS: None MILD MODERATE SEVERE _____

If you are POST-MENOPAUSAL do you have any significant MENOPAUSAL SYMPTOMS? YES NO

- HOT FLASHES NIGHT SWEATS VAGINAL DRYNESS OTHER _____

Are you currently SEXUALLY ACTIVE? YES NO WITH MEN WITH WOMEN

If YES, what do you use to PREVENT PREGNANCY? _____

Do you need to CHANGE your BIRTH CONTROL METHOD? YES NO

SOCIAL HISTORY:

Do you drink ALCOHOL? Rarely Occasionally Daily Never _____

Do you smoke? YES NO

If YES, check any that apply: CIGARETTES VAPING E-CIGARETTES MARIJUANA

Do you use any ILLICIT SUBSTANCES? YES NO _____

Are you MARRIED SINGLE WIDOWED DIVORCED SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? YES NO

If YES, what type of work do you do? (if you are a student please include this information as well):

Have you ever been a victim of DOMESTIC VIOLENCE? YES NO

REVIEW OF SYSTEMS:

Please **check** any SIGNIFICANT SYMPTOMS you currently experience: **NONE**

- **CONSTITUTIONAL:** weight gain weight loss fatigue loss of appetite fevers chills other _____
- **EYES:** blurred vision eye pain discharge from eye other _____
- **HEAD & NECK:** severe headaches sore throat nasal discharge nose bleeds decreased hearing
 lightheadedness other _____
- **BREAST:** lumps tenderness nipple discharge other _____
- **CARDIOVASCULAR:** chest pain irregular heartbeat fainting spells other _____
- **RESPIRATORY:** shortness of breath cough wheezing other _____
- **GASTROINTESTINAL:** nausea vomiting diarrhea constipation heartburn abdominal pain
 blood in stools incontinence of stools hemorrhoids other _____
- **GENITOURINARY:** urinary frequency pain with urination blood in urine urinary incontinence difficulty urinating
 vaginal discharge pain with intercourse bleeding with intercourse significant PMS
 other _____
- **SKIN:** rash itching acne abnormal hair growth other _____
- **NEURO:** headaches weakness numbness other _____
- **MUSCULOSKELETAL:** joint pain joint swelling muscle weakness muscle pain other _____
- **ENDOCRINE:** increased thirst increased urination hair loss heat intolerance cold intolerance
 other _____
- **PSYCHIATRIC:** anxiety depression confusion other _____
- **HEMATOLOGIC:** easy bruising easy bleeding lymph node enlargement other _____
- **ALLERGIC:** sinus allergies skin allergies other _____

I have filled out this form completely and to the best of my ability.

Signature _____ Date ____/____/____