Gynecology Information

embodywellness
OBSTETRICS • GYNECOLOGY

Name:

Date of Birth: / /

Why did you make this appointment?

What are you allergic to? (Please indicate reaction)

Medical History

(Please Circle Yes or No)

Have you ever had:

Seizure Disorder	Yes	No
High Blood Pressure	Yes	No
Hyperlipidemia	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Pelvic Disease	Yes	No
Venereal Disease	Yes	No
Mental Illness	Yes	No
Drug Dependency	Yes	No
Sexual Abuse	Yes	No

Previous Pregnancies

	Year	Months Pregnant?	Type of Delivery (Vaginal or C-Section)	Problems?
1.				
2.				
3.				
4.				
5.				

Current Medications

(Please include name and dosage)

Surgical History

Year	Operation	Hospital/Surgeon	City/State

Social History

How much do you smoke? _____

How much do you drink? _____

Do you use drugs or marijuana? Yes No

Gynecology History

Last mammogram: ___/___/___ Normal? Yes No

Last pap smear: ___/___/___ Normal? Yes No

Birth control method? _____

Do you perform self breast exams? Yes No

First day of last menstrual period? _____