35998 Zion Church Rd. - Frankford, DE 19945 - 302-278-0093 (phone) - 302-278-0096 (fax)

New Gynecology

Patient Name: ______________________________________ DOB: ________________

**Preventative Care**

When was your last PAP? _____________________

Have you had an abnormal PAP? Y N If so, when? _________________

Have you had a Bone Density screening? Y N If so, when? _________________

Have you had a Mammogram? Y N If so, when? _________________

Have you had an abnormal Mammogram? Y N If so, when? _________________

Have you had a Colonoscopy? Y N If so, when? _________________

**Health History**

How old were you when you began your period? _________________

When was the first day of your last period? __________________

Are your periods regular? Y N

How many days between periods? _______________

Is the flow: Light Mild Moderate Heavy

Cramping: Mild Moderate Severe

How many pregnancies have you had? _____________ (G)

How many children have you delivered? ____________ (P) Vaginal____ Cesarean ____

How many miscarriages/abortions have you had? ______

Is it possible you are pregnant? Y N

Are you planning to be pregnant in the next year? Y N

Are you sexually active? Y N

Are you in a monogamous relationship? Y N

Have you begun menopause? Y N

If yes, are you using any therapies/ remedies? Y N

If yes, what? __________________________________________

**Sexually Transmitted Disease (VD/STD)**

Have you ever been diagnosed with:

Chlamydia Gonorrhea HPV (warts) Herpes (HSV) HIV/AIDS Other: ____________

Have you been vaccinated against HPV? Y N

Have you had a new sexual partner in the past year? Y N

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**Birth Control/ Contraception**

Are you using contraception? Y N

Do you have an IUD? Y N

If so, what type? Skyla Mirena Paraguard (Copper)

Do you use an implantable birth control device? Y N

If so, when was it implanted? ___________________________

Do you use injectable birth control method? Y N

If so, when was the last injection? ________________________

Do you use birth control pills? Y N

If yes:

Type/Name Brand: ___________________________

Do you need a refill? Y N

Do you smoke? Y N

Do you have a history of the following:

| | | |
|---|---|---|
| Hypertension (high blood pressure) | Y | N |
| Blood Clots | Y | N |
| Migraine | Y | N |
| Renal Disease | Y | N |
| Liver Disease | Y | N |

Other side effects: _____________________________________

**Problems/ Procedures**

Have you had any of the following problems in the past year:

| | | |
|---|---|---|
| Abnormally heavy periods (make you light-headed, feel weak) | Y | N |
| Bleeding after intercourse (sex) | Y | N |
| Bleeding between your menses (periods) | Y | N |
| Post-menopausal bleeding (if applicable) | Y | N |
| Pelvic pain or pain during intercourse | Y | N |
| Do you have discharge | Y | N |
| Does it have an odor | Y | N |
| Do you have itching | Y | N |
| Do you have any gynecological concerns at this time? | Y | N |

If yes, please describe: _________________________________________

Have you had a hysterectomy? Y N

Subtotal (cervix remains) _______

Total (cervix removed) ________

Do you still have your ovaries? Y N

If no, reason for removal: _____________________________________________

Have you ever had any of the following problems or procedures:

Abnormal PAP Y N
If yes, date? ________________________
Problem? __________________________________________________
Colposcopy/ Cervical Biopsy/Laser Treatment of Cervix Y N
If yes, date? _________________________
Results? ___________________________________________________
Treatment for Vaginal Warts or Skin Cancers Y N
If yes, date? _________________________
Cancer Treatment Y N
If yes, date? ______________________. Type of Cancer: _________________
Chemo/ Radiation: ___________________________________________
Endometriosis Y N

Date of last menstrual period? ___________________

Any urinary tract, bladder, or kidney infections within the past year? Y N

Do you have any pain or burning during urination? Y N

Any blood in your urine? Y N

Any problems with control of urination? Y N

**Wellness**

Do you exercise? Y N
Type: Walking Cardio Weights Other: ________________
Do you take Vitamin D? Y N Amount: _______________
Do you take Calcium? Y N Amount: _______________

**Cervical Cancer Risk Screening**

| | | |
|---|---|---|
| Have you ever had an STD? | Y | N |
| Have you had sexual intercourse with >5 partners in your lifetime? | Y | N |
| Did you have sexual intercourse at <16 years old? | Y | N |
| Have you had >3 abnormal PAP's in the last 7 years? | Y | N |
| Did your mother take DES while she was pregnant with you? | Y | N |
| Have you ever had HPV/HPV vaccination? | Y | N |

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**Family History**

| ***Disease*** | ***Self*** | ***Mother*** | ***Father*** | ***Maternal Grandmother*** | ***Paternal Grandmother*** | ***Siblings*** | ***Other*** |
|---|---|---|---|---|---|---|---|
| ***Cancer:*** | | | | | | | |
| Breast | | | | | | | |
| Uterine/ Endometrial | | | | | | | |
| Cervical | | | | | | | |
| Ovarian | | | | | | | |
| Other | | | | | | | |
| | | | | | | | |
| ***Thyroid Disorders:*** | | | | | | | |
| Hyperthyroidism | | | | | | | |
| Hypothyroidism | | | | | | | |
| | | | | | | | |
| Polycystic Kidney Disease | | | | | | | |
| Polycystic Ovarian Disease | | | | | | | |
| Incontinence | | | | | | | |
| Psychiatric/ Mental Health | | | | | | | |

**Tobacco:**

Do you use tobacco? Y N
Cigarettes- packs/day? _________________
Chew- #/day? _________________
Pipe- #/day? __________________
Cigars- #/day? _________________
# of years smoking? ________________
Or Year Quit? __________________

**Drugs:**

Do you currently use recreational or street drugs? Y N
Have you ever given yourself street drugs with a needle? Y N