Print Form

Queen City Physicians Gynecological History Form

Patient Name _____ Date of Birth _____

Reason for Today's Visit _____

Primary Care Physician _____

Any other Physician(s) you are currently seeing _____

List all known allergies _____

List all prescription and over-the-counter medications you are currently taking (please include vitamins and herbals

Type Here

List all prior hospitalizations or surgical procedures, serious accidents, or chronic illnesses/ conditions

Type Here

Imunizations/Tuberculosis Skin Test _____

Do/Did you use tobacco? _____ How long? _____ Amount _____ packs per week

Do/Did you consume alcohol? _____ How long? _____ Amount _____ per week

Do/Did you drink coffee? _____ How long? _____ Amount _____ cups per week

Do you wear a seatbelt? _____

Have you received a bloodtransfusion ? _____ If so, when? _____

Do you have a living will ? _____ Do you have a power of attorney ? _____

Gynecological History

Date of Last Menstrual Period _____ Began at what age? _____ Length of days _____

Changes in Periods? _____

Are you currently sexually active? _____ Number of partners lifetime? _____ Partners sex(s) is _____

Present method of birth control? _____ Have you used an IUD or birth control pills ? _____ How long? _____

When was your last pap? _____ What was the result ? _____ Have you ever had an abnormal pap ? _____

Do you do Breast Self-Examination s? _____ Have you been exposed to Diethylstibestrol (DES)? _____

Obstetrics History

of Pregnancies _____ # of Abortions _____ # of Miscarriages _____

# of Premature Births > 37 weeks _____ # of Live Births _____

	Childs Date of Birth	Weight at Birth	Sex	Weeks Pregnant	Type of Delivery (vaginal, cesarean, etc)
Child 1					
Child 2					
Child 3					
Child 4					

Any pregnancy complications? ☐ Diabetes ☐ Hypertension/ High Blood Pressure ☐ Preeclampsia/ Toxemia

Other _____

Any history of depression before or after pregnancy? _____ If yes, treatment _____

Family History

	Name	Living/Deceased	Age now/ at death	Cause of death	History of illness
Mother					
Father					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					
Sibling/ Child					