

**PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
FEMALE PATIENT HISTORY: GYNECOLOGY**

1. Identifying Information

Date: _____

Name: _____ Partner's Name _____

Address _____ City _____ State _____ Zip _____

Telephone No: Day () _____ Evening () _____ Cell () _____

Referring Physician: Name _____ Address _____

Age: _____ Date of Birth: _____ Partner's Age _____ Date of Birth _____

Partner's Cell # _____

Race: (check one) Caucasian African/American Asian Hispanic Jewish
 Mediterranean Other

II. Pregnancy History

How many pregnancies (including abortions) have you had? _____

*	When (year)	How long to conceive (months)	Fertility Therapy Used (Y/N)	Is Current Partner the Father (Y/N)	Duration of Pregnancy (months)	Outcome*	Complications
1st pregnancy							
2 nd pregnancy							
3 rd pregnancy							
4 th pregnancy							
5 th pregnancy							

*Outcomes: Vaginal deliver=VD; Cesarean Section=CS; Abortion=AB; Miscarriage=MS; Ectopic (tubal)= EP

III. Gynecological History

How old were you when you started having periods: _____ Date your last period started _____

Are your periods regular without taking medication? Yes No

If yes, how many days between periods (start until start) _____

If no, how many periods per year do you have _____

Do you take medicine (birth control pills or progesterone) to start your period: Yes No

How many days do your periods last: _____ Do you have cramps with your periods: Yes No

If yes, are they Mild Moderate Severe

Have you ever missed work or school due to menstrual pain: Yes No

Do you have pain with intercourse: Yes No

Were you ever diagnosed with endometriosis: Yes No

What type of treatments / surgeries have you had for endometriosis _____

Have you had a hysterectomy _____ When and why _____

Have you had your ovary (ies) removed _____ When and why _____

Are you on hormones _____ What type (s) _____

When did you start hormone therapy _____

Are you sexually active now: _____ How many present partners? _____

How many lifetime sexual partners? _____

What type of contraception have you used in the past: (Check all that apply)

___ Birth Control ___ IUD ___ Depo-Provera (birth control shots)

___ Condoms ___ Diaphragm ___ Foams/Jellies

___ Withdrawal ___ Rhythm ___ Tubal Ligation

Contraceptive Complications: _____

When did you last use contraception: _____

Have you ever had an abnormal Pap smear : ___ Yes ___ No If so, when _____

What was done about it: _____

When was your last Pap smear: _____

Have you ever had any of the following: (Check all that apply)

___ Gonorrhea	___ Venereal Warts	___ Syphilis
___ Chlamydia	___ Genital Herpes	___ Pelvic Inflammatory Disease (PHD)

IV. Medical History

Do you have or have you ever had: (Check all that apply)

___ Asthma	___ Depression / Anxiety	___ Polycystic Ovarian Syndrome
___ Anemia	___ Diabetes	___ Ovarian Cysts
___ Appendicitis	___ Gallbladder problems	___ Pneumonia
___ Arthritis	___ Heart Disease	___ Rheumatic Fever
___ Blood Transfusions	___ Hepatitis	___ Rubella (German Measles)
___ Breast Discharge	___ Hirsutism (excess facial hair)	___ Scarlet Fever
___ Breast Pain	___ High Blood Pressure	___ Seizures
___ Chicken Pox	___ Kidney Infections	___ Thyroid Problems
___ Chronic Bronchitis	___ Liver Problems	___ Tuberculosis (TB)
___ Chronic Headaches	___ Migraine Headaches	___ Ulcers
___ Colitis	___ Neurological Problems	___ Vision Problems

Current Medications _____

Natural, herbal or alternative medicines _____

Are you allergic to any medications: Yes No What: _____

Are you allergic to latex Yes No; Iodine/Shrimp/Shellfish Yes No; Peanuts Yes No

Have you ever had surgery before: Yes No Date and type: _____

V. Social History

Current or recent Employer / Position: _____

Do you drink alcohol: Yes No Number of drinks per week _____

Do you smoke: Yes No Number of cigarettes per day: _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.) Yes No
If yes, specify: _____

Do you have a special exercise program: Yes No
If yes, type: _____

Are you on a special diet: Yes No
If yes, type _____

VI. Review of Systems:

What is your height: _____ Current weight: _____ Ideal weight: _____

Have you had more than a 10 pound weight gain/loss this past year Yes No
If so how much: _____ Was this intentional: Yes No

What is your blood type: (if known) _____

Do you have problems with your eyes, ears, nose or throat: Yes No
If yes, please specify: _____

Do you have heart problems, chest pain or irregular heart beat: Yes No
If yes, please specify: _____

Do you have asthma, wheezing, shortness of breath or trouble breathing: Yes No
If yes, please specify: _____

Do you have breast pain, breast discharge or a lump in your breast: Yes No
If yes, please specify: _____

Do you have chronic nausea, twitching, stomach pain, blood in your stool or a history of ulcers: Yes No
If yes, please specify: _____

Do you have urinary burning, incontinence or blood in your urine: Yes No

If yes, please specify: _____

Do you have chronic joint or muscle pain or swelling: Yes No

If yes, please specify: _____

Do you have any chronic skin rashes or moles: Yes No

If yes, please specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or body hair growth:

Yes No

If yes, please specify: _____

Do you or any family members have a history of blood clots or bleeding disorders _____

Other current or past problems not listed above: _____

VII. Family History

Any history of breast cancer, ovarian or colon cancer: Yes No

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: Yes No

Do any family members have significant health problems or inherited diseases: Yes No

Check all that apply:

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain / Spinal Defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Who: _____

Please bring this form with you to your first appointment. Ensure that records from your current or past physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

I confirm that all the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization.

Signed: _____ Date: _____