Santa Rosa MEDICAL GROUP

Gynecologic/Obstetrical History

Date: ____________________

Gynecologic History

Age when period started: _______ How many days does it last? ______

Period occurs every: ☐ <21 days ☐ 21-30 days ☐ 30-35 days ☐ >35 days

Do you have menstrual cramps/pain? _____ How severe? ☐ Mild ☐ Moderate ☐ Severe

Do you ever bleed between periods? _______ After intercourse? _______

What do you use for contraception? ____

Have you ever had: **Please Check Only Those That Apply**

_____ Fibroids _____ Ovarian Cysts _____ Vaginal Dryness/Itching

_____ Endometriosis _____ Pelvic Inflammatory Disease _____ Hot Flashes

_____ Genital Herpes _____ Genital Warts _____ Yeast Infection

_____ Gonorrhea _____ Syphilis _____ Bacterial Infection

Have you gone through Menopause? ______ At what age? _____

Date of last Pap Smear? ______________ Was it normal? _____

Have you ever had an abnormal Pap Smear? _____

If so, did you have: ☐ Cryo ☐ Colpo ☐ Leep

Date of last Mammogram? ____________ Was it normal? ______

Do you perform self breast exams regularly? _____

Date of last colonoscopy? ____________

Sexual History

Are you sexually active?

☐ Yes ☐ No

Do you ever have pain with intercourse?

☐ Yes ☐ No

Is your sex life satisfactory?

☐ Yes ☐ No

Sexual preference:

☐ Male

☐ Female

☐ Both

Obstetrical History

How many times have you been pregnant? ________ Live births? _________

Baby Weight: _______________ Type of Delivery: ________________

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Urinary Problems

Do You Have:

____ Urine Loss with Cough

____ Urine Loss with Urgency

____ Urinary Urgency

____ Urinary Frequency

____ Pain with Urination

____ Blood in Urine

____ Bladder Infections

____ Difficulty Urinating

____ Bed Wetting

____ Waking at Night to Urinate

____ Wear Incontinence Products

____ Uncontrollable Loss of Stool

Have you recently had or experienced any of the following:

_____ Constipation _____ Chest Pain _____ Weakness/Numbness

_____ Diarrhea _____ Heart Attack _____ Suicidal Thoughts

_____ Soiling Pants with Stool _____ Skin Problems _____ Swollen Glands

_____ Blood in Stool _____ Abnormal Hair Growth _____ Breast Lumps

_____ Vomiting Blood _____ Headaches _____ Hoarseness

_____Appetite Change _____ Change in Vision _____ Coughing up Blood

_____ Sudden Weight Change _____ Change in Hearing _____ Difficulty Breathing

_____ Depression _____ Difficulty Sleeping

Patient Name:____________________________________ Date of Birth:____________________ M / F