

GYNECOLOGY CONSULTATION

The information provided will become part of your medical record and is totally **confidential**. This information will assist us in our effort to provide quality health care.

Name: _____ Date: _____
(last) (first) (middle initial)

Please note the reason for your visit today _____

Who referred you? _____

ALLERGIES:

Please note any allergies or reactions to medications or other agents. None

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

CURRENT PRESCRIPTION MEDICATIONS:

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS. None

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Please list any non-prescription medications, supplements and/or herbal remedies you take: _____

GYNECOLOGIC STATUS***Menstrual History: (skip to next section if you are Post-Menopausal)***

Date your last period began: _____

Was it normal? no yes

How often are your periods? _____

How many days do your periods last? _____

Flow: heavy average light

Do you think you have a problem with your period? no yes-Explain: _____

Post-Menopausal: (skip if your are pre-menopausal)

Post Menopausal since age: _____ Have you ever been on Hormone Replacement Therapy? no yes

Why or why not? _____ If so for how long? _____

Are you experiencing any vaginal bleeding? no yes

Sexual History:

Have you ever had sex or been sexually active? no yes If yes, are you currently having sex? no yes

Do your partner(s) have a penis vagina (check all that apply)

Have you or your partner(s) had new sexual partners since your last STD/STI test? no yes

Do you have concerns about sexually transmitted infections? no yes unsure

Do you have any concerns about sex or your sexual health? no yes

Do you have any concerns about vaginal dryness or pain with intercourse? no yes

Do you have any concerns about libido? no yes

Are you planning a pregnancy ? now in future never unsure

If at risk for unplanned pregnancy, what method of birth control are you using? _____

OBSTETRICAL HISTORY

How many times have you been pregnant? _____ #children do you have? _____ # delivered vaginally? _____

MEDICAL & GYNECOLOGIC HISTORY: Have you ever been diagnosed with any of the following None

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Cervical Pap | <input type="checkbox"/> Gastrointestinal Problem(s) | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |
| <input type="checkbox"/> Absent Periods (amenorrhea) | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> STI/Sexually Transmitted Infections |
| <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Headache (migraine) | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Hyperlipidemia (high cholesterol) | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cerebrovascular disease (stroke/TIA) | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Infertility | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> CAD/Heart Attack/Angina | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Drugs |
| <input type="checkbox"/> Bleeding tendency (coagulation defect) | <input type="checkbox"/> Crohns | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Thromboembolic disorder (blood clots in legs or lungs or a tendency to form clots) |
| <input type="checkbox"/> DES Exposure in Utero (when your mother was pregnant with you) | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Urinary Tract Infection (UTI) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Uterine Anomaly (abnormal uterine structure) |
| <input type="checkbox"/> Only In pregnancy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Painful periods (dysmenorrhea) | <input type="checkbox"/> Menstrual Disorders | <input type="checkbox"/> Vaginal dysplasia (precancer) |
| <input type="checkbox"/> Pain with sex (dyspareunia) | <input type="checkbox"/> Irregular or infrequent periods | <input type="checkbox"/> Vulvar dysplasia (precancer) |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Frequent or heavy periods | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Vulvovaginitis |
| <input type="checkbox"/> Polycystic ovaries | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Yeast |
| <input type="checkbox"/> Endometriosis or Adenomyosis | <input type="checkbox"/> Ovarian Cyst, type: _____ | <input type="checkbox"/> BV |
| <input type="checkbox"/> Fibroids, uterine | <input type="checkbox"/> Pelvic Pain, chronic | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> Other: _____ |

SURGICAL/HOSPITALIZATION HISTORY

List all hospitalization, operations or major injuries (excluding pregnancy):

DATE	HOSPITALIZATIONS, OPERATIONS, OR MAJOR INJURIES

Do you smoke cigarettes? never formerly currently If currently, Amount/PPD: _____

Primary Care Provider _____

PCP's Address (if not Atrius) _____

PCP Phone # (if not Atrius) _____