



**MAA**  
Women's Health

# GYN FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

BP: \_\_\_\_\_ / \_\_\_\_\_ PR: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ Temp: \_\_\_\_\_

## Do you have problems with

- |                         |                          |                         |                          |                              |                          |
|-------------------------|--------------------------|-------------------------|--------------------------|------------------------------|--------------------------|
| Difficulty sleeping     | <input type="checkbox"/> | Headache                | <input type="checkbox"/> | Vomiting/ Nausea             | <input type="checkbox"/> |
| Sudden wgt gain/loss    | <input type="checkbox"/> | mouth lesions           | <input type="checkbox"/> | Digestion and bowels         | <input type="checkbox"/> |
| Decreased energy        | <input type="checkbox"/> | Difficulty swallowing   | <input type="checkbox"/> | Loss of sensation            | <input type="checkbox"/> |
| Decreased appetite      | <input type="checkbox"/> | Change in voice         | <input type="checkbox"/> | Breast lumps/ pain           | <input type="checkbox"/> |
| Problems with memory    | <input type="checkbox"/> | Cough                   | <input type="checkbox"/> | Vaginal discharge            | <input type="checkbox"/> |
| Blood in urine or stool | <input type="checkbox"/> | Difficulty breathing    | <input type="checkbox"/> | Abnormal menstruation        | <input type="checkbox"/> |
| Lumps in body           | <input type="checkbox"/> | Chest pain              | <input type="checkbox"/> | Pain in abdomen              | <input type="checkbox"/> |
| Skin changes            | <input type="checkbox"/> | Irregular heart rate    | <input type="checkbox"/> | Pelvic pain                  | <input type="checkbox"/> |
| Nose/throat/voice       | <input type="checkbox"/> | Swelling/ fluid in legs | <input type="checkbox"/> | Lesions vulvar area          | <input type="checkbox"/> |
| Eyes or vision          | <input type="checkbox"/> | Joint swelling/ pain    | <input type="checkbox"/> | Problems with urination      | <input type="checkbox"/> |
| Hearing prob/ ears      | <input type="checkbox"/> | Difficulty walking      | <input type="checkbox"/> | Problems with passing stools | <input type="checkbox"/> |

## Medical History:

- |                        |                          |                       |                          |
|------------------------|--------------------------|-----------------------|--------------------------|
| Hypertension           | <input type="checkbox"/> | Ehlers danlos         | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | Osteoporosis          | <input type="checkbox"/> |
| Heart problems         | <input type="checkbox"/> | Sleep Apnea           | <input type="checkbox"/> |
| Lung disease chronic   | <input type="checkbox"/> | Kidney disease        | <input type="checkbox"/> |
| Asthma                 | <input type="checkbox"/> | Bladder problems      | <input type="checkbox"/> |
| Neurlogic disorder     | <input type="checkbox"/> | Spine defects/surgery | <input type="checkbox"/> |
| Migraines              | <input type="checkbox"/> | Muscle disorder       | <input type="checkbox"/> |
| Seizures               | <input type="checkbox"/> | Tuberculosis          | <input type="checkbox"/> |
| Stroke                 | <input type="checkbox"/> | Lupus                 | <input type="checkbox"/> |
| Bowel disease          | <input type="checkbox"/> | Rhematoid arthritis   | <input type="checkbox"/> |
| Stomach ulcers         | <input type="checkbox"/> | Autoimmune disorder   | <input type="checkbox"/> |
| Gall bladder           | <input type="checkbox"/> | Cancer                | <input type="checkbox"/> |
| Liver disease          | <input type="checkbox"/> | Psychiatric disorder  | <input type="checkbox"/> |
| Anemia                 | <input type="checkbox"/> | Depression/ anxiety   | <input type="checkbox"/> |
| Bleeding disorder      | <input type="checkbox"/> | Eating disorder       | <input type="checkbox"/> |
| Blood transfusion      | <input type="checkbox"/> |                       |                          |
| Blood clots lung/ legs | <input type="checkbox"/> |                       |                          |
| Thyroid prob           | <input type="checkbox"/> |                       |                          |
| Genetic disorder       | <input type="checkbox"/> |                       |                          |

## Surgical History (Name/ year).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergies (Medication/reaction).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medications (Name/dose/usage).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## OB History:

| GRAVIDA | FULL TERM | PRETERM | ABORTIONS | MISCARRIAGE(S) | ECTOPIC | LIVING CHILDREN |
|---------|-----------|---------|-----------|----------------|---------|-----------------|
|         |           |         |           |                |         |                 |

**Pregnancy Complications:**

**Social History**

Smoking/ day: \_\_\_\_\_  
Past use pack/ yrs: \_\_\_\_\_  
Alcohol/ week: \_\_\_\_\_  
Street drugs: \_\_\_\_\_  
Marital status: \_\_\_\_\_

**Health maintenance:**

Last Pap: \_\_\_\_\_  
Last mammogram: \_\_\_\_\_  
Last colonoscopy: \_\_\_\_\_  
Last bone density: \_\_\_\_\_

**Menstrual History:**

Age cycles started (yrs): \_\_\_\_\_  
Age cycles stopped (yrs): \_\_\_\_\_  
Last menstrual period: \_\_\_\_\_  
1<sup>st</sup> day of cycle to next: \_\_\_\_\_  
Days of bleeding: \_\_\_\_\_  
Sanitary product / day: \_\_\_\_\_  
Menstrual pain (1- 10): \_\_\_\_\_  
Pain meds used: \_\_\_\_\_  
Regular cycles?? \_\_\_\_\_  
Bleeding between cycles: \_\_\_\_\_  
Spotting after menopause: \_\_\_\_\_

**Gyn Procedures/ Hx:**

Abnormal pap: \_\_\_\_\_  
Colposcopy: \_\_\_\_\_  
Cone bx cervix: \_\_\_\_\_  
Cryotherapy: \_\_\_\_\_  
Tubal ligation: \_\_\_\_\_  
Ablation uterus: \_\_\_\_\_  
Hysterectomy: \_\_\_\_\_  
Fibroids: \_\_\_\_\_  
Endometriosis: \_\_\_\_\_  
Des exposure: \_\_\_\_\_

**Family Medical History**

Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brothers: \_\_\_\_\_  
Sisters: \_\_\_\_\_  
Children: \_\_\_\_\_  
Cousins: \_\_\_\_\_  
Cancer: \_\_\_\_\_

Sugary drinks (Oz/day): \_\_\_\_\_  
Juice (Oz/day): \_\_\_\_\_  
Dairy Intake per day: \_\_\_\_\_  
Exercise per week (mins): \_\_\_\_\_  
Living condition: \_\_\_\_\_

**Immunization History:**

Gardasil: \_\_\_\_\_ MMR: \_\_\_\_\_  
Tetanus: \_\_\_\_\_ Shingles: \_\_\_\_\_  
Hepatitis B: \_\_\_\_\_ RSV: \_\_\_\_\_  
Pneumonia: \_\_\_\_\_

**Sexual History:**

Sexually active (Y/N) \_\_\_\_\_  
Birth control used: \_\_\_\_\_  
Age at first intercourse (yrs): \_\_\_\_\_  
Current partner (mo/ yrs): \_\_\_\_\_  
Lifetime partners (number): \_\_\_\_\_  
Homosexual/bisexual (Y/N): \_\_\_\_\_  
Heterosexual (Y/N): \_\_\_\_\_  
Difficult intercourse (Y/N): \_\_\_\_\_  
Bleeding after sex? \_\_\_\_\_  
Infertility: \_\_\_\_\_

**STD Hx:**

Pelvic infl dz: \_\_\_\_\_  
Chlamydia: \_\_\_\_\_  
Gonorrhea: \_\_\_\_\_  
Herpes: \_\_\_\_\_  
HPV: \_\_\_\_\_  
Genital Warts: \_\_\_\_\_  
Hepatitis B: \_\_\_\_\_  
Hepatitis C: \_\_\_\_\_  
HIV \_\_\_\_\_  
Syphilis: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_