PERSONAL HISTORY FORM

Please complete this form in its entirety and return to reception. If not applicable, please write N/A.

NAME:	DOB:	AGE:
REASON FOR VISIT:		
DESCRIPTION OF CURRENT GYNECOLOGIC PROBLEM:		

COMMON GYNECOLOGICAL PROBLEMS (If you have or had any of the following previously, check the box and explain.)

☐ ABNORMAL PAPS	
☐ ABNORMAL MAMMOGRAMS	
☐ BLEEDING AFTER MENOPAUSE	
☐ INFERTILITY/ENDOMETRIOSIS	
☐ FIBROIDS OR OVARIAN CYSTS	
☐ SEXUALLY TRANSMITTED INFECTIONS	
☐ INCONTINENCE	
☐ IN UTERO EXPOSURE TO DES	

PAST DELIVERY HISTORY	#1	#2	#3	#4	#5	#6
DATE OF DELIVERY						
TYPE (C-SECTION, VAGINAL, ETC)						
SEX OF INFANT						
BIRTH WEIGHT						
COMPLICATIONS (YES OR NO)						
OTHER PREGNANCIES?						

MENSTRUAL AND SEXUAL HISTORY		LAST MENSTRUAL PERIOD	
SEXUALLY ACTIVE?	☐ YES ☐ NO ☐ NEVER	AGE OF FIRST PERIOD	
SEX PARTNERS ARE:	☐ MEN ☐ WOMEN ☐ BOTH	AGE OF MENOPAUSE	
GENDER IDENTITY:	☐ MALE ☐ FEMALE ☐ OTHER	FREQUENCY OF PERIOD	
CONDOM USE?	☐ YES ☐ NO ☐ SOMETIMES	DURATION OF FLOW	
BIRTH CONTROL:	☐ NO ☐ YES, TYPE:	AMOUNT OF FLOW	☐ LIGHT ☐ MODERATE ☐ HEAVY

PAST SURGICAL HISTORY

SURGERIES, HOSPITALIZATIONS, MAJOR ACCIDENTS	YEAR	REASON
ANESTHETIC COMPLICATION? ☐ NO ☐ YES, REACTION:		

SOCIAL HISTORY

OCCUPATION:		ABUSE OR DOMESTIC VIOLENCE (PAST OR PRESENT): ☐ YES ☐ NO	
SEAT BELT: ☐ YES ☐ NO	HEALTHY DIET: ☐ YES ☐ NO	EXERCISE: ☐ NO ☐ YES, TIMES PER WEEK:	
TOBACCO? ☐ YES ☐ NO	PACK PER DAY?	HOW LONG?	DATE QUIT?
ALCOHOL? ☐ YES ☐ NO	TYPE?	AMOUNT?	HOW OFTEN?
DRUG USE (INCLUDE MARIJUANA)? ☐ YES ☐ NO	TYPE?	AMOUNT?	HOW OFTEN?

PAST MEDICAL HISTORY

ILLNESS	MYSELF	FAMILY	WHO? AGE AT DIAGNOSIS?	ILLNESS	MYSELF	FAMILY	WHO? AGE AT DIAGNOSIS?
Anemia	□	□		UTI	□	□	
High Blood Pressure	□	□		Interstitial Cystitis	□	□	
High Cholesterol	□	□		Lupus	□	□	
Heart Disease	□	□		Arthritis	□	□	
Stroke	□	□		Back Injury	□	□	
Diabetes	□	□		Osteoporosis	□	□	
COPD/Emphysema	□	□		Liver Disease/Hepatitis	□	□	
Asthma	□	□		Inflammatory Bowel Disease	□	□	
Seizures	□	□		Celiac Disease	□	□	
Thyroid Problems	□	□		IBS	□	□	
Mental Illness	□	□		Gall bladder disease	□	□	
History of Suicide attempt	□	□		Blood clot in leg/lung	□	□	
Depression	□	□		Breast Cancer	□	□	
Anxiety	□	□		Ovarian Cancer	□	□	
Eating Disorder	□	□		Uterine Cancer	□	□	
Migraines	□	□		Colon Cancer	□	□	
Other Problem	□	□		Other Cancer	□	□	

HEALTH MAINTENANCE

DATE OF LAST ANNUAL EXAM:	DATE OF LAST COLONOSCOPY:
DATE OF LAST PAP SMEAR:	DATE OF LAST DEXA OR BONE SCAN:
DATE OF LAST MAMMOGRAM:	**PCP**:
PRIOR GYNECOLOGIST:	**IS THIS DOCTOR WITH UPMC? □ YES □ NO**
PHARMACY INFORMATION:	

VACCINATIONS

HAVE YOU HAD THE INFLUENZA VACCINE?	□ YES; WHEN:	□ NO
HAVE YOU HAD CHICKEN POX OR THE VACCINE?	□ YES; WHEN:	□ NO
HAVE YOU HAD THE GARDASIL (HPV) VACCINE?	□ YES; WHEN:	□ NO
DID YOU HAVE THE MMR VACCINE AS A CHILD?	□ YES; WHEN:	□ NO

ALLERGIES

MEDICATION	REACTION

MEDICATIONS AND SUPPLEMENTS – INCLUDE NAME, DOSE, FREQUENCY

FORM COMPLETED BY: DATE: