PRINCETON MEDICAL GROUP - GYNECOLOGIC MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ Date Form Completed: _____

Reason for your visit _____

Menstrual History

Age of first period _____ Are your periods monthly? (i.e. every 21-35 days): My periods are every _____ days

First Day of Last Menstrual Period (LMP) _____ If in Menopause, Age / Year your period stopped _____

Are your periods heavy or painful? _____ Do you bleed between periods or after sex? _____

Using Contraception? ____ No ____ Yes If yes, type of contraception _____

Obstetric History

Past Pregnancies
(including miscarriages, abortions, and ectopic pregnancies)

Date	Sex	Birth Weight	Gestational age (weeks)	Type of Delivery	Anesthesia	Place of Delivery	Comments/Complaints

Medical History

(Circle here if all are negative)

	YES	NO
1. Diabetes	☐	☐
2. Hypertension	☐	☐
3. Heart Disease	☐	☐
4. Autoimmune disorder	☐	☐
5. Kidney disease/UTI	☐	☐
6. Neurologic/epilepsy	☐	☐
7. Psychiatric	☐	☐
8. Depression/anxiety	☐	☐
postpartum depression	☐	☐
9. Hepatitis/liver disease	☐	☐
10. Varicositis/phlebitis	☐	☐
11. Thryoid dysfunction	☐	☐
12. Trauma/violence	☐	☐
13. History of blood transfusions	☐	☐
List use per week:		
14. Tobacco _____		
15. Alcohol _____		
16. illicit/recreational drugs _____		
17. Blood clots (DVT)	☐	☐
18. Lung issues (Asthma, Tuberculosis)	☐	☐
19. Seasonal allergies	☐	☐
20. Are you up to date on vaccines?	☐	☐
21. Breast issues / surgery	☐	☐
22. GYN surgery	☐	☐
23. Operations/hospitalizations	☐	☐
24. Anesthesia complications	☐	☐
25. History of abnormal PAP	☐	☐
26. Uterine anomaly/DES	☐	☐
27. Infertility	☐	☐
28. ART (Assisted Reproductive Therapy)	☐	☐
29. Relevant family history	☐	☐
30. Other issues _____		

Infection History

(Circle here if all negative)

	yes	no
1. Live with someone with TB or exposed to TB	☐	☐
2. Patient or partner has history of genital herpes	☐	☐
3. Current rash or viral illness	☐	☐
4. Hepatitis B, C	☐	☐
5. History of STD	☐	☐
HPV	☐	☐
Gonorrhea	☐	☐
HIV	☐	☐
Chlamydia	☐	☐
Syphillis	☐	☐
6. Other		

Past Medical History

Surgical History (surgery/year)

Allergies Detail Latex Allergies ☐ Yes ☐ No

(Are you allergic to any medications?) ☐ Yes ☐ No

If yes, please list: _____

Family History Detail (cancer / med problems / blood clots)

Family Member (Mat/Pat)	Medical Problem(s) and age at diagnosis

Medical Summary - cont'd

Any concerns that you wish to discuss?	Current Medications
(Please indicate any health problems or symptoms that you are having at this time	(Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, herbal medicines and illicit recreational drugs)

Genetic History Ancestry Risk Factor Question

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please indicate if you, the baby's father, or any relative in either family are of these backgrounds

___ Eastern Europe Jewish ancestry (Ashkenazi Jewish, etc)
___ European Ancestry
___ Mediterranean Ancestry or Southeast Asian Ancestry
___ African American
___ Asian
___ Other (please explain)

Have you or a family member been tested for an inherited cancer gene mutation? (Ex. BRCA, Lynch) ☐ Yes ☐ No

If you have been pregnant, did you ever have a child with a birth defect? ☐ Yes ☐ No

PAP SMEAR / MAMMOGRAM HISTORY

Date of last pap smear:_____

Have you had abnormal pap smears? □ No □ Yes

Date of last mammogram:_____

Have you had an abnormal mammo? □ No □ Yes

Have you had treatment for abnormal smear? □ No □ Yes

If yes, what type(s) of treatment have you had? (i.e. colposcopy, cone, LEEP) _____

Other Comments (in addition, please list any other concerns you have)

Social History

Information on you

Your Education _____

Your relationship status _____

Your occupation _____

	Yes	No
Are you sexually active?	☐	☐
Male partner?	☐	☐
Female partner?	☐	☐
Both?	☐	☐

	Yes	No
Are you a vegetarian?	☐	☐
If yes, do you eat protein / eggs?	☐	☐
Do you exercise regularly?	☐	☐
	☐	☐
Is Blood Transfusion Acceptable?	☐	☐

Name of Primary Care Provider

_____

Name / Address of your Pharmacy

_____

Patient Signature **Patient Name:** **Date**

format updated 12-2020 AS