Plymouth State University

Health Services
GYN History Form

Date:_____
Name: _____ Age:_____ DOB:_____

1. REASON FOR VISIT (describe any special problems or symptoms you would like to discuss with your provider today)
_____ Check Up _____ Pain _____ Bleeding _____ Discharge _____ Incontinence
_____ Pregnancy _____ Contraception Advice _____ Infertility _____ Menopause
_____ OTHER: _____

2. MENSTRUAL HISTORY:
First day of last period _____
Are periods regular? _____
Flow lasts how many days? _____
Usual number of days apart _____
Do you have cramps? _____
Age periods began? _____
When was last pap smear?_____
Method of birth control? _____

3. PAST HISTORY: (use back side as needed)
List any medications now taking: _____
_____
Allergies to medications _____
Previous surgery *(approximate year if known)* _____
_____
_____
Present or Previous illness (such as high blood pressure, anemia, diabetes, hepatitis, rheumatic fever, meningitis, convulsions, phlebitis)
_____
_____
_____

4. SOCIAL HISTORY:
Do you smoke? _____ How much? _____ How long? _____ Have you ever smoked? _____
Do you ever drink alcohol? _____ How much and how often? _____

5. FAMILY HISTORY:

	Age (if known)	**Major Illness**	**Cause of death (if known)**
Mother			
Father			
Brothers/Sisters			

Does anyone in your family have? (please include Uncles, Aunts, Grandparents, Cousins and their relationship to you)
Breast cancer _____
Ovarian cancer _____
Diabetes _____
Heart disease _____
High blood pressure _____
Thyrold disorder _____

6. ANNUAL UPDATE:
Please inform us of any changes in your health over the past year.
Date: _____
_____
_____
_____