FAMILY DOCTORS OF VICKSBURG PC
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Gynecologic History

Date: ___________________________

Name: ____ DOB: ____________________________________

The following questions will help us determine how best to take care of you. Please answer the questions that apply to you.

How many times have you been pregnant? ______ How many children have you had? ______
How many miscarriages have you had? ______ Abortions? ______
Do you have a problem with vaginal discharge? ______ When was your last pap smear? _______________
Have you ever had an abnormal pap smear? ______ If so, when? _______________________
Age at onset of sexual activity ___<16___>16 Number of sexual partners: last year____ lifetime _____
Have you ever had a sexually transmitted disease? (i.e. gonorrhea, venereal warts and herpes) ___________
If so, what disease? ____
Do you have pelvic pain? _________________ Do you have pain with intercourse? _______________________
Have you ever had a mammogram? ________ When was your last mammogram? _______________________
Do you do self breast exams? ______________ Have you noticed any lumps in your breasts? ______________
Do you have burning or pain with urination? __________ Do you have to urinate frequently? _____________
Do you have to wear a pad because of leaking urine? ____
Do you leak with coughing/sneezing? ____
Do you smoke? _________________ If so, how many packs a day? _____________________________
Have you ever had phlebitis? _____ Hepatitis? _____ Migraine Headaches? _____ High Blood Pressure? _____

<u>If you still have periods, please answer the following questions. (If NOT, go to the next section)</u>
What was the first day of your last menstrual period? ______________________________________
How many days do you bleed? _________________ How often do you have periods? ___________________
Do you pass clots with your period? ____
Do you bleed between periods? _________________ Do you bleed after intercourse? __________________
Do you have cramps or pain before or during your period? ___________________________________
What is your present form of birth control? Tubal Ligation ____ Vasectomy____
Birth Control Pills____ Condoms____ Other____

<u>If you stopped having periods, answer the following questions.</u>
How old were you when you stopped having periods? ____
Have you ever been on estrogen or hormone replacement? ____________________________________
If yes, when and for how long? ____
Have you ever had a bone mineral density (osteoporosis) testing? ____________________________

Is there a family history of:	If yes, who?
Uterine Cancer	
Ovarian Cancer	
Breast Cancer	
Osteoporosis/hip fractures	