



FEMALE HEALTH ASSOCIATES OF NORTH TEXAS

1327 Hemphill Street, Suite 100

Fort Worth, Texas 76104

NEW PATIENT GYN HISTORY

Today's Date: _____

Name: _____

Primary Care Physician: _____

Marital Status: _____

Occupation: _____

Reason for Visit/Complaint: _____

Current Medications: _____

Allergies: _____

MENSTRUAL HISTORY

Onset Age: _____ Cycle Every _____ Days Length: _____ Days

Menopausal

Last Menstrual Period: ____/____/____

Hysterectomy

Hysterectomy w/removal of ovaries

Hysterectomy w/one ovary removal

Ablation

PREGNANCY HISTORY

TOTAL Pregnancies: _____ Births _____ Living Children _____ Abortions _____

Pregnancy Complications: _____

Current Contraception: _____ Previous Contraception _____

Problems w/Contraception _____

Last Pap Smear ____/____/____ Results _____

History of Previous Abnormal Pap Smear: YES/NO If Yes, When: ____/____/____

Treatment _____ Follow-Up Treatment: _____

Last Mammogram ____/____/____ Results _____

Last Bone Density ____/____/____ Results _____

SOCIAL HISTORY

DETAILS

Alcohol Yes No

Drinks per Week _____ Type of Alcohol _____

Caffeine Yes No

Drinks per Week _____ Type of Caffeine _____

Tobacco Yes No

Packs per Week _____

Substance Abuse Yes No

How Often _____ Details _____

Exercise Yes No

How Often _____

Occupation Yes No

CHRONIC MEDICAL CONDITIONS: _____

MEDICAL HISTORY – Past & Present

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Asthma/Bronchites | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood/Black Bowel Movement | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thrombophlebitis/Blood Clot |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Problems with Muscles, Bones,
Nerves, or Joints | <input type="checkbox"/> Visual Disorders |
| <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Vomited Blood |

COMMENTS _____:

PAST SURGERIES (Please note the month & Year): _____

SERIOUS INJURIES, ACCIDENTS, ILLNESSES: _____

BLOOD TRANSFUSIONS (Please note the month & Year): _____

FAMILY HISTORY (check conditions which apply to grandparents, parents, siblings, or child)

- | | | |
|--|---|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Negative Family History |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Adopted |
| <input type="checkbox"/> Cancer, other | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Thrombophlebitis/Blood Clot |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Tuberculosis |

PERSONAL GYNECOLOGICAL HISTORY – Past & Present:

- | | |
|--|---|
| <input type="checkbox"/> Vaginal discharge or irritation | <input type="checkbox"/> Pelvic Abnormality |
| <input type="checkbox"/> Difficulty getting pregnant | <input type="checkbox"/> Frequent, prolonged, or heavy vaginal bleeding |
| <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Urinary burning, frequency, or urgency |
| <input type="checkbox"/> Hot flashes/Menopausal symptoms | <input type="checkbox"/> Breast lump, pain, or discharge |
| <input type="checkbox"/> Concern about STD Exposure | <input type="checkbox"/> Low abdominal or pelvic pain or heaviness, low back pain |
| <input type="checkbox"/> Loss of Urine | <input type="checkbox"/> Do you practice self breast examinations? |

COMMENTS: _____