Patient Name:

Past Gynecologic History

How many days from the first day of one period to the first day of the NEXT period?
If it's not regular, give the range.

How many days do you bleed during your period?
Give the range, if applicable.

*How many pads/tampons do you use in one day during your heaviest bleeding?

What was the date of the first day of your last period?

Do you have bleeding between periods or after intercourse?	Yes	No
Do you have pain with your periods?	Yes	No
Do you have pain with intercourse?	Yes	No
*Do you have pain at other times?	Yes	No
What things make it worse or better?		

How long has your pain been present (years, months…)?

Do you have any symptoms of a vaginal infection?	Yes	No
When was your last Pap smear?	_____ year	
Have you ever had an abnormal Pap smear?	Yes	No
Do you leak urine?	Yes	No
*Get the urge to go and can't make it to the washroom?	Yes	No
*Cough, sneeze, laugh and leak?	Yes	No
*Have you had any hot flashes?	Yes	No

Past Obstetrical History

How many pregnancies have you had?

How many babies have you delivered?

What are you currently using for contraception?

Past Medical History (List all illnesses, diseases and conditions for which you've seen a physician)

Past Surgical History (List ALL procedures you've had)

Patient Name:

Social History

*Are you a smoker? Yes No

*Are you in a relationship? Yes No

What do you do for work?

What do you do for physical activity?

Medications (Include vitamins and herbs)

Allergies (Provide the allergen and the reaction you have)

What bothers you most about the reason you've been referred?

Review Questions (over the last year)

Do you feel hot or cold all the time?
Have you noticed changes in your skin?
Have you noticed changes in your hair pattern (chest, abdomen, face)?
Do you have any breast discharge?
Have you noticed changes in your vision?
Have you noticed changes in your appetite, bowel movements?
Do you have any bloating, or increased size of your belly?
Has your weight changed much?
Have you noticed any new lumps or bumps?
Have you noticed any new chest pain or shortness of breath?

Have you ever:

Been sexually/physically/emotionally abused? Yes No

In childhood:

Were you often without enough to eat, had to wear dirty clothes, and had no one to protect you?
Were your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
Was a household member depressed or mentally ill, or did a household member attempt suicide?

Is there anything else Doctor Fahey should know about you or your medical history?