GYN PATIENT INFORMATION SHEET

Date: _____ Patient Name: _____
D.O.B.: _____ Last Menstrual Period: _____ Height: _____ Weight: _____
Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Other ___
Primary Care Physician: _____
Present Birth Control: _____
Past Birth Control Methods: _____

MEDICATIONS

[ ] No Medications

Brand/Generic Name	Prescribing Physician	Start Date	Dosage/How Often

ADDITIONAL MEDICATIONS – Attach List

ALLERGIES

[ ] No Known Allergies

Allergy	Reaction

PREGNANCY HISTORY

Year	Birth Weight	Sex of Child	Complications

- Number of Pregnancies: _____
- Number of Full Term Pregnancies: _____
- Number of Preterm Pregnancies: _____
- Number of Miscarriages: _____
- Number of Abortions: _____
- Number of Live Births: _____
- Number of Vaginal Deliveries: _____
- Number of Caesarean Deliveries: _____
- Number of Living Children: _____

PAST MEDICAL HISTORY

[ ] No Known Medical History

Disease	Year Diagnosed	Treatment	Resolved? (Circle One)	
			Yes	No
			Yes	No

GYN PATIENT INFORMATION SHEET

			Yes	No

PAST SURGICAL HISTORY [ ] No Surgical History

Name of Procedure	Diagnosis	Year Diagnosed	Date of Procedure

FAMILY HISTORY (indicate Maternal[M] **OR** Paternal[P] association for "Other Relative(s)")

Diagnosis	Mother	Father	Sister	Brother	Other Relative(s)
Alive and Well					
Alcoholism					
Asthma					
Autoimmune Disorder					
Breast Cancer					
Cervical Cancer					
Colon Cancer					
Ovarian Cancer					
Blood Clotting Problems					
Congenital Heart Defect					
Heart Attack					
Stroke					
Cystic Fibrosis					
Depression					
Developmental Delay					
Diabetes					
Down Syndrome					
Hemophilia-A					
High Cholesterol					
High Blood Pressure					
Mental Illness					
Mental Retardation					
Muscular Dystrophy					
Seizure Disorder					
Sickle Cell Disease					
Spina Bifida					
Thyroid Disease					
(OTHER)					