Gynecological History:

What age did you start having periods: _____

When was the first day of your last menstrual period? _____

Have you gone through menopause? **YES NO** If so, what age? _____

When was your last pap test? _____ The Results: _____

Have you ever had an abnormal pap test? **YES NO**

If so, when and what tests/treatments were done? _____

Pregnancy History:

Pregnancies: _____ Full Term Pregnancies: _____ Living: _____

Miscarriages: _____ Abortions: _____

Past Pregnancies, Please Fill Out to the Best of Your Ability				
Date of Birth	**Sex (Please Circle)**	**Delivery (Please Circle)**	**Delivered at how many weeks?**	**Complications Or Concerns?**
	M F	Vaginal C-section		
	M F	Vaginal C-section		
	M F	Vaginal C-section		
	M F	Vaginal C-section		
	M F	Vaginal C-section		
	M F	Vaginal C-section		

Have you ever been diagnosed with any of the below in the past?

Chlamydia Gonorrhea Trichomonas Hepatitis Syphilis Herpes HIV

Polycystic Ovarian Syndrome (PCOS) Endometriosis Fibroids Ovarian Cysts Prolapse

Other gynecological history: _____

Family History

Family Members	Alcohol or Drug Abuse	COPD or Emphysema	Diabetes	High Blood Pressure	High Cholesterol	Heart Attack	Kidney Disease	Stroke	Thyroid Disease	Osteoporosis
Mother										
Father										
Brother										
Sister										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Family History and Genetic Screening:

Family history of breast cancer: **YES NO** If so, Who? _____

Family history of ovarian cancer: **YES NO** If so, Who? _____

Family history of uterine cancer: **YES NO** If so, Who? _____

Family history of colon cancer: **YES NO** If so, Who? _____