GONZAGA FAMILY HEALTH

Supplementary Medical History for Women

Your Name: _____ Your Date of Birth: _____

Gynecological History

The date of my last pap smear was	Yes	No
If you are post-menopausal, what age were you at the onset of menopause?	Yes	No
Did you ever receive the HPV vaccine?	Yes	No
Are you sexually active?	Yes	No
Do you have any sexual issues you would like to discuss with the provider	Yes	No
Do you have STI or an STD?	Yes	No
Do you have children?	Yes	No
If you gave birth to your children, how old were you for your first child?	Yes	No
Do you currently use birth control?	Yes	No
If you do use birth control, what method do you use?	Yes	No
What was the date of your LMP?	Yes	No
Flow?	Yes	No
Duration of flow (days):	Yes	No
What is the frequency of your menstrual cycle (days):	Yes	No
Do you have monthly menses?	Yes	No
How old were you at menarche (when you got your first period)?	Yes	No
What was the date of your last colonoscopy?	Yes	No
What was the date of your last mammogram?		

Obstetrics History (If applicable)

Total number of children			
Did you have a full-term pregnancy?			
Did you ever have a premature pregnancy?	Yes	No	
Have you had a spontaneous abortion?	Yes	No	
Have you ever had an induced abortion?	Yes	No	
Did you experience an ectopic pregnancy or birth (baby was in the wrong position)?	Yes	No	
Did you ever have multiple births, like twins or triplets?	Yes	No	
Did you ever have a stillborn?	Yes	No	
PAST PREGNANCIES	Yes	No	
Dates of your child's birth or children's births:	Yes	No	
Labor length (in hours) for your birth/s:	Yes	No	
Was anesthesia used?	Yes	No	
Did you experience preterm labor?	Yes	No	
What was your delivery site?	Yes	No	

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Perinatal History (if applicable)

Di you have an abnormal AFP?			
Did you have an abnormal ultrasound?			
Did you experience bleeding?	Yes	No	
Do you have a history of gestational diabetes?	Yes	No	
Do you have HIV?	Yes	No	
Do you have hepatitis?	Yes	No	
Did you have herpes?	Yes	No	
Did you have any infections?	Yes	No	
Did you have multiple gestations?	Yes	No	
Did you take any medications during pregnancy?	Yes	No	

Birth History (if applicable)

Do you know your child's APGAR score?	Score:	I don't know	
What type of delivery did you have (circle a choice)	Vaginal C-Section VBAC		
Do you know your child's bilirubin level?	Levels:	I don't know	
What was your child's birthweight?	Weight:	I don't know	
Did your child have any breathing problems?	Yes	No	
Do you know your child's weight at discharge?	Weight:	I don't know	
Was there any fetal distress?	Yes	No	
What was the gestational age when your child was born?	Age:	I don't know	
Did your child pass the newborn hearing screening?	Yes	No	
Did your child have any infections at birth?	Yes	No	
Was your child intubated?	Yes	No	
Was your child jaundiced?	Yes	No	
Were there any maternal infections?	Yes	No	
Was your child admitted to the NICU?	Yes	No	
Did you experience premature rupture of membranes?	Yes	No	
Were there any bruises on the child's scalp?	Yes	No	

In this section, please list any other concerns or relevant history you have.