# Marlboro College Total Health Center

Initial History – GYN

**Medical History:** (indicate if current or past)

- High Blood Pressure
- Heart Attack
- High Cholesterol
- Diabetes
- Thyroid Disease
- Depression /Anxiety
- Other Psychological Illness
- Endometriosis
- Breast Cancer
- Osteoporosis
- Lactose Intolerance
- Eating Disorder
- Stomach Ulcer
- Loss of Appetite
- Cancer __________
- Liver Disease
- Anemia
- Easy bruising
- Bleeding Disorder
- Heart Murmur
- Blood Clots
- Gallbladder Disease
- Diarrhea/Constipation
- Crohns/Colitis
- Hernia
- Kidney Stones
- Kidney Infection
- Urinary Tract Infections
- Pneumonia
- Allergies
- Asthma
- Alcoholism
- Skin Issues
- Seizure/convulsions
- Frequent Headaches
- Chronic Fatigue
- Weight Loss/Gain
- Substance mis-use

**Surgical History:**

Surgery Date

______________________________________________________________

______________________________________________________________

**Family History:** (include any blood relatives with any of the following)

- High blood pressure________________________
- Heart attacks______________________________
- High cholesterol___________________________
- Diabetes_________________________________
- Thyroid disease____________________________
- Depression_______________________________
- Osteoporosis_____________________________
- Endometriosis_____________________________
- Breast cancer_____________________________
- Ovarian cancer____________________________
- Endometrial cancer_________________________
- Anemia__________________________________
- Alcoholism_______________________________
- Substance Use____________________________
- Other ___________________________________

Do you have any drug allergies?_____________________________________________

**Medications:** (please include vitamins, supplements, naturopathic/homeopathic remedies)

| Name | Dose | Frequency | Use |
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## Gynecologic/Obstetric History:

Age at first period__________ Date of last menstrual period______________
Periods occur every _____ days and last for _________days.
Pregnancies____ Births_____ Miscarriages_____ Abortions_____________
Birth Control method(s) used:_______________________________________________
Last PAP smear__________________________________________________________
Have you ever had an abnormal PAP?__________ If yes, when?____________________
Have you ever had:

- Chlamydia
- Gonorrhea
- Trichomonas
- Chronic Pelvic Pain
- Syphilis
- Yeast Infections
- Bacterial Vaginosis
- Other
- PID
- Herpes
- Genital Warts

Do you perform self breast exams?______________________ How often?_________
Do you have any of the following with your period?

- Heavy bleeding
- Menstrual cramps
- Mood changes
- Breast tenderness
- Headaches
- Spotting between periods
- Irregular periods

Do you have pain or bleeding after intercourse?
Are you currently sexually active?
Number of sexual partners in the last 12 months?
Do you have sex with men, women or both?

## Social History:

Do you use tobacco?_________________
If yes, what kind: __________ how much___________# of years________
Do you drink alcohol? _______________
If yes, what kind:___________ how often _________how many drinks________
Have you ever felt you ought to cut down on your drinking? _____________
Have people annoyed you by criticizing your drinking? ________________
Have you ever felt bad or guilty about your drinking? __________________
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Do you use drugs?___________________
If yes, what kind:___________ how often__________
Do you wear seat belts? ___________________
Do you wear a bike helmet?________________
Do you exercise regularly?________________
Do you use sunscreen?_____________________
Do you eat regular meals?__________________
Do you get calcium through food or supplements? ______________
Do you have guns in your home? ______________________
Do you feel safe in your home? _______________________
Do you feel safe with your partner? ____________________
Have you experienced trauma, abuse or violence? _________
Is this something you would like to address or discuss today? ____________

Do you have any other particular concerns you'd like to address today?