

GYNECOLOGIC FLOW SHEET

Name _____ Address _____
 Age _____ Date of birth _____ Marital Status _____ Occupation _____
 Telephone: Home _____ Business _____ Todays Date _____

PREGNANCY HISTORY (including spontaneous and induced abortions/ tubal pregnancies)

Year	Sex	Name	Weight	Full Term	Vag. C/S	Complications
1				Yes No <input type="checkbox"/> <input type="checkbox"/>		
2				Yes No <input type="checkbox"/> <input type="checkbox"/>		
3				Yes No <input type="checkbox"/> <input type="checkbox"/>		
4				Yes No <input type="checkbox"/> <input type="checkbox"/>		
5				Yes No <input type="checkbox"/> <input type="checkbox"/>		
6				Yes No <input type="checkbox"/> <input type="checkbox"/>		

Current contraceptive method _____
 Previous methods _____

GYNECOLOGIC HISTORY: Last period started _____ Age of first period _____
 Days between period (start to start) _____ Days flow _____ Pad/ Tampons per day _____
 Menstrual pain _____ Bleeding between periods _____
 Prior vaginal infections Yeast Trichomonas Other _____
 Bleeding after intercourse _____ Pain with intercourse _____
 Last Paps Smear _____ Any abnormal Paps? _____
 Mammogram? _____ When? _____

PAST MEDICAL HISTORY

Allergies to: Medication _____ Food _____ Environmental _____
 Current medications _____
 Hospitalization admissions (with dates) _____
 Operations (with dates) _____

Yes	No	Describe	Yes	No	Describe
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Anemia _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Transfusions _____
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/ Clots _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendencies _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Urinary infx _____	<input type="checkbox"/>	<input type="checkbox"/>	Smoking _____
<input type="checkbox"/>	<input type="checkbox"/>	Other renal disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	Drugs _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	DES exposure _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea, Herpes, Syphilis Chlamydia
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric _____	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts (circle those that apply)
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

FAMILY HISTORY

Yes	No	Diabetes _____	Yes	No	Breast cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	GYN cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____