FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Gynecologic Health History Questionnaire

Name ______________________ **Date of Birth** ______________

Personal Health History

Check if you have had any of the following

☐ Abnormal Pap Smears	☐ Sexually Transmitted Infections

Social History

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian

Are you being sexually abused, threatened or hurt? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Any history of physical abuse? ☐ Yes ☐ No Emotional abuse? ☐ Yes ☐ No Psychological abuse? ☐ Yes ☐ No

Gynecologic Health History

First day of last period:

Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain ☐ Cramping

Days of flow: Time between periods:

☐ Pain or bleeding with sex or after sex

☐ Vaginal bleeding/discharge

Menopause: ☐ Yes ☐ No Age:

Hormone Replacement Therapy: ☐ Never ☐ Past ☐ Current

Any sexual activity within the last year? ☐ Yes ☐ No

Birth control method:

Obstetric Health History

Number of pregnancies:

Miscarriages: Abortions:

Ectopic Pregnancies:

Pregnancy Term	Type of Delivery
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean

Pregnancy Complications:

Previous Surgical Procedures

Procedure	Year
Breast Augmentation	
Breast Reduction	
Lumpectomy	
Mastectomy	
Dilatation & Curettage	
Hysterectomy	
Tubal Ligation	
Other Gynecological Surgery	

Family History

Condition	Relative	
Breast Cancer		
Colon Cancer		
Endometrial Cancer		
Ovarian Cancer		
Uterine Cancer		
Pancreatic Cancer		
Multiple people on one side of your family diagnosed with cancer?	Yes	No

Health Maintenance

Test	Month	Year
Mammogram		
Pap Smear/Pelvic Exam		
Colonoscopy		
Bone Density		

Immunization	Month	Year
Gardasil (HPV) Vaccine		

Patient/Guardian Signature: ______________________ Date: ______________

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