



**SEXUAL HISTORY** E

50. Do you have a sexual partner? Yes  No
51. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes  No

**PAST OBSTETRICAL/GYNECOLOGICAL SURGERY** F

Check any that apply: or 81.  None

SURGERY	YEAR	SURGERY	YEAR
52. <input type="checkbox"/> D & C		61. <input type="checkbox"/> ovarian surgery	
53. <input type="checkbox"/> hysteroscopy		62. <input type="checkbox"/> L cyst(s) removed	
54. <input type="checkbox"/> infertility surgery		63. <input type="checkbox"/> R cyst(s) removed	
55. <input type="checkbox"/> tuboplasty		64. <input type="checkbox"/> L ovary removed	
56. <input type="checkbox"/> tubal ligation		65. <input type="checkbox"/> R ovary removed	
57. <input type="checkbox"/> laparoscopy		66. <input type="checkbox"/> vaginal or bladder repair for prolapse or incontinence	
58. <input type="checkbox"/> hysterectomy (vaginal)		67. <input type="checkbox"/> caesarean section	
59. <input type="checkbox"/> hysterectomy (abdominal)		68. <input type="checkbox"/> other (specify) _____	
60. <input type="checkbox"/> myomectomy			

**OTHER PAST GYNECOLOGICAL HISTORY**

- Check any that apply: or 69.  None
70.  Veneral warts      71.  Herpes - genital      72.  Gonorrhoea      73.  Chlamydia
74.  Pelvic inflammatory disease      75.  Endometriosis      76.  Vaginal infections      77.  Syphilis
78.  Other \_\_\_\_\_

**PAP SMEAR/MAMMOGRAM HISTORY If yes, what type(s) of treatment have you had?** G

79.  Date of last Pap smear: \_\_\_\_\_

80.  Have you had abnormal smears? No  Yes  YEAR \_\_\_\_\_

81.  Have you had treatment for abnormal smears? No  Yes  82.  cryotherapy

83.  laser

84.  cone biopsy

86.  Date of last mammogram: \_\_\_\_\_ month \_\_\_\_\_ year

87.  Have you had an abnormal mammogram: No  Yes  85.  loop excision (leep)

**PAST SURGICAL HISTORY (Not OB/GYN)** H

Check any that apply: or 124.  None

SURGERY	YEAR	SURGERY	YEAR
88. <input type="checkbox"/> Thyroid surgery		94. <input type="checkbox"/> Urinary/bladder surgery	
89. <input type="checkbox"/> Appendectomy		95. <input type="checkbox"/> Heart surgery	
90. <input type="checkbox"/> Bowel surgery		96. <input type="checkbox"/> Bone surgery	
91. <input type="checkbox"/> Stomach surgery		97. <input type="checkbox"/> Joint surgery	
92. <input type="checkbox"/> Hernia surgery		98. <input type="checkbox"/> Ear, nose or throat surgery (including tonsillectomy)	
93. <input type="checkbox"/> Cholecystectomy (gall bladder)		99. <input type="checkbox"/> Mastectomy	
		100. <input type="checkbox"/> Breast biopsy	
		101. <input type="checkbox"/> Facial surgery	
		102. <input type="checkbox"/> Eye surgery	
		103. <input type="checkbox"/> Varicose vein surgery	
		104. <input type="checkbox"/> Other (specify) _____	

**PAST MEDICAL HISTORY (Not OB/gyn)** I

- Check any that apply: or 105.  None
- |   |   |   |   |
|---|---|---|---|
| 106. <input type="checkbox"/> Arthritis           | 108. a) <input type="checkbox"/> Diet controlled    | 113. <input type="checkbox"/> Kidney Disease                      | 119. <input type="checkbox"/> Asthma          |
| 107. <input type="checkbox"/> Diabetes:           | 109. b) <input type="checkbox"/> Pill controlled    | 114. <input type="checkbox"/> Gallstones                          | 120. <input type="checkbox"/> Emphysema       |
|   | 110. c) <input type="checkbox"/> Insulin controlled | 115. <input type="checkbox"/> Liver Disease (including hepatitis) | 121. <input type="checkbox"/> Bronchitis      |
| 111. <input type="checkbox"/> High blood pressure |   | 116. <input type="checkbox"/> Epilepsy                            | 122. <input type="checkbox"/> HIV+            |
| 112. <input type="checkbox"/> Heart disease       |   | 117. <input type="checkbox"/> Blood Transfusions                  | 123. <input type="checkbox"/> Eating Disorder |
|   |   | 118. <input type="checkbox"/> Thyroid disease                     | 124. <input type="checkbox"/> Other           |

**CURRENT MEDICATIONS (include dose (amount) per day)** J

125. <input type="checkbox"/> None _____	134. <input type="checkbox"/> for epilepsy _____
126. <input type="checkbox"/> for diabetes _____	135. <input type="checkbox"/> for fluid retention _____
127. <input type="checkbox"/> for blood pressure _____	136. <input type="checkbox"/> for asthma _____
128. <input type="checkbox"/> for thyroid _____	137. <input type="checkbox"/> for allergy _____
129. <input type="checkbox"/> for infection _____	138. <input type="checkbox"/> for depression _____
130. <input type="checkbox"/> for sleep _____	139. <input type="checkbox"/> for anxiety _____
131. <input type="checkbox"/> for pain _____	140. <input type="checkbox"/> hormonal _____ <small>(include birth control pills)</small>
132. <input type="checkbox"/> for heart _____	141. <input type="checkbox"/> for skin _____
133. <input type="checkbox"/> for ulcers _____	142. <input type="checkbox"/> Other _____

**DO YOU CURRENTLY?:** K

143. Smoke No  Yes  \_\_\_\_\_ packs/day
144. Use alcohol No  Yes  \_\_\_\_\_<sup>189.</sup> wine (glasses/day); \_\_\_\_\_<sup>145.</sup> beer (bottles/day); \_\_\_\_\_<sup>146.</sup> hard liquid (oz./day)
147. Use illicit drugs No  Yes  \_\_\_\_\_<sup>type</sup> \_\_\_\_\_<sup>amount</sup>
148. Exercise: Type \_\_\_\_\_ How often \_\_\_\_\_

**DRUG ALLERGIES** L

149. No  Yes  List: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** M

150.  Diabetes      151.  Heart Disease      152.  Breast Cancer      153.  Other \_\_\_\_\_
154.  Ovarian Cancer      155.  Endometrial Cancer      156.  Colon Cancer
- If "yes" for 150-156, please list affected relatives \_\_\_\_\_
157.  None of the above

**OTHER SYMPTOMS** N

- Have you had recent?:
- |  |  |  |   |
|--|--|--|---|
| 158. <input type="checkbox"/> weight loss      | 161. <input type="checkbox"/> change in exercise tolerance | 164. <input type="checkbox"/> change in urinary function | 167. <input type="checkbox"/> none of the above |
| 159. <input type="checkbox"/> weight gain      | 162. <input type="checkbox"/> hair growth                  | 165. <input type="checkbox"/> hot flushes/flushes        | 168. <input type="checkbox"/> other _____       |
| 160. <input type="checkbox"/> change in energy | 163. <input type="checkbox"/> hair loss                    | 166. <input type="checkbox"/> breast discharge           |   |