VANDERBILT UNIVERSITY
MEDICAL CENTER

Center for Women's Health
Medical History

Patient Completed Information

Patient Label or Patient Identifiers

Name: _____ Date of Birth: _____ Date: _____

List all medical problems:	List all operations with approximate date:
List all medicine, vitamins, minerals, herbs, etc.:	**List all drug allergies:**

List all pregnancies and outcome (including miscarriages and terminations)

Month & Year	Male or Female	Vaginal or C-Section	Hospital of Delivery	Complications during Pregnancy or Delivery

Gynecology History

How old were you when you started your periods?		Did breast / hair growth begin at about the same time?
When was the start of your last menstrual period?		Are your periods regular? Y / N Do you have excessive or irregular bleeding? (circle) Excessive Irregular Both
Have you ever had an abnormal Pap Smear?	Y / N	Treatment:
Have you ever had an abnormal mammogram?	Y / N	Treatment:
Have you had a sexually transmitted disease?	Y / N	Which? When? How was it treated?
Do you have constant pelvic pain?	Y / N	Describe:
Do you have pain with intercourse?	Y / N	Describe:
Do you have pain with periods?	Y / N	Describe:
Do you use a regular method of contraception?	Y / N	What kind?
Do you have a history of infertility?	Y / N	Are you trying to conceive? How long have you been trying?

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Social / Personal Health History

Are you currently: Married Single Divorced? Name of significant other: _____

Are you currently sexually active? Y / N

Monogamous? Y / N If not, how many partners? _____

Do you feel that you are physical or emotionally abused or unsafe? _____

How many cigarettes do you smoke? _____

How much alcohol do you drink? _____

Do you use any recreational drugs? _____

What kind of work do you do? _____

Are you exposed to chemicals or hazards? Y / N

Family History (mother / father / brothers / sisters / grandparents / aunts / uncles

High Blood Pressure	Liver Disease	Breast Cancer
Heart Disease	TB or Other Infectious Disease	Gynecologic Cancer
Stroke / TIA	Asthma or Respiratory Disease	Colon Cancer
Diabetes Mellitus	Osteoporosis	Other Cancer
Other Medical Conditions:		

Patient / Legal Representative Print Name: _____

Patient / Legal Representative Signature: _____

Relation: _____ Date: _____ Time: _____