VANDERBILT UNIVERSITY
MEDICAL CENTER

New GYN Patient Information

Your Name: _____ Today's Date: ___/___/____

Date of Birth: ___/___/_____ Social Security # _____

Home Phone: _____ Day Phone: _____

Personal History

Occupation: _____ Spouse/Significant Other's Name and Occupation: _____

Are you? Single_____ Married_____ Widowed_____ Divorced _____ Separated _____ Partnered_____

Emergency Contact Person_____ Phone #_____

Are you? African American_____ Asian _____ Caucasian _____ Hispanic _____ Other _____

Do you have a Primary Care Physician? _____ Phone #_____

Are you here for your Annual Exam? ☐ YES ☐ NO

If not, please list your reason for this visit or the main concern you want to discuss with your healthcare provider.

_____

_____

List any medication or food allergies:

ALLERGIC TO	TYPE OF REACTION

List all medications (i.e. prescription, non-prescription, herbal/nutritional supplements) you are taking

If you are a current Vanderbilt patient, simply update this information * Please use a different sheet of paper if you need more room*

DRUG	DOSE	TIMES TAKEN	TAKEN FOR

Have you ever been hospitalized or diagnosed with a medical condition? ☐ YES ☐ NO

If yes, please explain _____

_____

_____

Have you had any operations or surgical procedures? ☐ YES ☐ NO

Type of Procedure	Date of Procedure	Surgeon	Hospital

* Please use a different sheet of paper if you need more room*

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GYN History

What was the first day of your last period?	**LMP** _____	
How old were you when you started having periods?	_____	
What was the date of your last pap smear?	_____	
Have you ever had an abnormal pap smear? Abnormality? _____	Yes	No
Have you had 5 or more sexual partners in your lifetime?	Yes	No
Did you have sexual activity under 16 years of age?	Yes	No
Are you still having periods?	Yes	No
How often do you have your period? [i.e.: monthly, every 2 weeks, etc.] _____		
Is your overall flow: LIGHT MEDIUM HEAVY How many days to you bleed? _____		
Do you have pain with your periods?	Yes	No
Do you have pelvic pain at times other than your period?	Yes	No
Have you ever had an infection in your tubes or ovaries?	Yes	No
Are any of the following symptoms debilitating and/or do they interfere with your life before you start your period? Check here if not applicable ☐		
Headache	Yes	No
Irritability	Yes	No
Moodiness	Yes	No
Bloating	Yes	No
Breast Tenderness	Yes	No
Cravings (chocolate, salt, sweet)	Yes	No
Other:		

_____

_____

_____

Do you have recurrent bladder problems?	Yes	No
Do you have problems with loss of urine or stool? (which one _____)	Yes	No
Are you sexually active?	Yes	No
Are you using contraception? Type:_____	Yes	No
OPTIONAL – Do you have sex with men, women or both?	_____	
Do you have pain with any sexual encounter?	Yes	No
Do you have bleeding after any sexual encounter?	Yes	No
Do you have abnormal vaginal discharge?	Yes	No
Have you ever been treated for Herpes? Venereal warts? Gonorrhea? Chlamydia? Etc? Which: _____ When: _____	Yes	No
Do you perform self breast exams?	Yes	No
Have you had a mammogram? When: _____ Where: _____	Yes	No
Do you have any of the following menopausal complaints? Check here if not applicable ☐		
Hot flashes	Yes	No
Drier skin	Yes	No
Vaginal spotting	Yes	No
Hair more brittle	Yes	No
Memory changes	Yes	No
Vaginal dryness	Yes	No
Leaking bladder	Yes	No
Decreased sex drive	Yes	No
Other:		

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Have you ever been pregnant? □ YES or □ NO

OB History:

Pregnancy #	Month & Year of birth	Male or Female	Birth Weight	Vaginal birth, c-section, miscarriage, or abortion
1				
2				
3				
4				
5				

* Please use a different sheet of paper if you need more room*

Family History of Cancer

Check here if not applicable ☐

	Breast, Colon, Ovarian, or Uterine Cancer	Age at time of diagnosis.
Yourself		
Mother		
Sister		
Daughter		
Mother's Side		
Grandmother		
Aunt(s)		
Cousin(s)		
Father's Side		
Grandmother		
Aunt(s)		
Cousin(s)		

_____

_____

_____

_____

_____

Medical History

	YOU	Family – List the relationship
High cholesterol		
Heart disease		
High blood pressure		
Blood clots or stroke		
Lung disease		
Osteoporosis		
Asthma		
Seasonal allergies		
Tuberculosis		
Diabetes		
Thyroid problems		
Liver disease		
Stomach or bowel problems		
Blood transfusions		
Kidney or bladder problems		
Anemia		
Bleeding or clotting disorders		
AIDS (HIV)		
Birth defects or inherited diseases		

_____

_____

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Review of Systems

Fever / Chills	Yes	No
Headache / Sinusitis	Yes	No
Neck pain / limitation of movement	Yes	No
Chest pain or pressure	Yes	No
Cough, wheeze, or shortness of breath	Yes	No
Depression / Anxiety	Yes	No
Nausea / Vomiting	Yes	No
Pain or frequency with urination	Yes	No
Dizziness	Yes	No
Joint stiffness / joint pain	Yes	No
Recurrent diarrhea or constipation	Yes	No
Vaginal rash / worrisome lesion or itching	Yes	No
Weight gain or loss	Yes	No
Visual changes	Yes	No
Hot or cold intolerance	Yes	No
Unusual hair growth or loss	Yes	No
Irregular or rapid heart beat	Yes	No
Stomach pain or discomfort	Yes	No
Blood in stool	Yes	No
Black or tarry stool	Yes	No
Numbness in hands or feet	Yes	No
Pain in legs or feet	Yes	No
Seizures or convulsions	Yes	No
Problems with sleeping	Yes	No
Sexual abuse	Yes	No
Domestic violence	Yes	No

_____

_____

_____

_____

Health Maintenance

Do you smoke? # of cigarettes per day: _____	Yes	No
Are you an ex-smoker? # of days/months/years of abstinence_____	Yes	No
Do you drink alcohol? # of drinks per week: _____	Yes	No
Do you exercise weekly? # of times per week: _____	Yes	No
Do you use recreational drugs? Type: _____	Yes	No
Do you drink coffee / caffeine? # of cups per day: _____	Yes	No
Do you feel safe at home?	Yes	No

Patient Signature

_____

Date _____

I have reviewed this history with the patient

Provider Signature

_____

Date _____

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