

NAME: _____ BIRTHDATE: _____ DATE: _____

OBSTETRICAL AND GYNECOLOGICAL INFORMATION SHEET

Reason for visit: _____

GYN Problems - Recent (X if positive)

- _____ Vaginal discharge, odor, irritation
- _____ Sexual problems
- _____ Bleeding problems
 - _____ No menses or infrequent menses
 - _____ Irregular menses
 - _____ Heavy menses
 - _____ Abnormal bleeding or spotting
- _____ Pain
 - _____ Painful urination
 - _____ Painful intercourse
 - _____ Painful menses
 - _____ Abdominal pain
 - _____ Pelvic pain
- _____ Breast problems
 - _____ Painful breasts
 - _____ Breast lump
 - _____ Nipple discharge
- _____ Other _____

GYN History (X if positive)

- _____ Mother took DES while pregnant
- _____ Abnormal pap
- _____ Cauterization or freezing of cervix
- _____ Gonorrhea, syphilis, or chlamydia
- _____ Herpes
- _____ Severe pelvic infection
- _____ Pelvic cysts or tumors
- _____ Breast cysts or tumors
- _____ Frequent bladder infections
- _____ Rectal bleeding
- _____ Severe constipation
- _____ Chronic diarrhea
- _____ Surgery on female organs
- _____ Tubal ligation
- _____ Other _____

Date of last pap smear _____
 Date of mammograms _____

MENSTRUAL HISTORY

First day of last period _____
 Age at first period _____
 Periods generally come every _____
 days and last _____ days.
 They are generally light/moderate/
 heavy.

PREGNANCY HISTORY

- _____ # times pregnant
- _____ # term births
- _____ # premature births
- _____ # miscarriages
- _____ # abortions
- _____ # living children

| Date of Birth | Wt. | Sex | DELIVERY RECORD | | Complications | |
|---------------|-----|-----|---------------------|---------------------------------------------|---------------|------|
| | | | Length of Pregnancy | Type of Delivery (Vag., Forceps, C-section) | Maternal | Baby |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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BIRTH CONTROL:

| Method | Brand Name | Dates of Usage | Reason for discontinuing |
|---------------------|------------|----------------|--------------------------|
| Birth control pills | | | |
| IUD | | | |
| Diaphragm | | | |
| Foam | | | |
| Condoms | | | |