Next Generation
WOMEN'S IMAGING AND MATERNAL-FETAL MEDICINE

GYN HISTORY FORM

Please help us to learn more about your OB and GYN conditions by filling out this form. The more we know, the better we can care for you. Thank you.

Name:_____ **Referring MD:**_____

Age:_____**Height:** _____**Weight:**____ **When was your last period?**_____

How many living children do you have? _____
Number of vaginal deliveries? _____
Number of cesarean deliveries? _____
Number of pregnancy terminations? _____
Number of miscarriages? _____
Have you had any GYN surgery? (What kind? When?)_____
_____

Please answer yes or no:	NO	YES
Do you have a history of infertility?		
Have you had an ectopic pregnancy before?		
Have you ever been told you have fibroids?		
Have you ever been told you have polyps?		
Have you ever been told you have ovarian cysts?		
Have you ever been told you have a uterine malformation?		
Do you have excessive or irregular vaginal bleeding?		
Do you have pelvic pain?		
Have you had a GYN cancer?		
Have you had breast cancer?		
Are you taking tamoxifen?		
Are you BRCA1 or BRCA2 positive?		
Has anyone in your family had breast or GYN cancer?		
Could you be pregnant?		

What kind of birth control do you use?_____

What medicines are you taking? _____

Anything else you think we should know? _____
_____
_____

I answered these questions to the best of my knowledge.

Signature:_____

Print name:_____**Date:**_____