



**WOMEN'S GYNEOLOGIC HISTORY:**

**For women:** # pregnancies \_\_\_\_\_ # deliveries \_\_\_\_\_ # abortions \_\_\_\_\_ # miscarriages: \_\_\_\_\_

First day, most recent period: \_\_\_\_\_ Age at first period: \_\_\_\_\_ Frequency of periods: \_\_\_\_\_ Length of each: \_\_\_\_\_

**FAMILY HISTORY:**

	Living?	Age (or age at death)	List serious illnesses
Mother	(Y) (N)	_____	_____
Father	(Y) (N)	_____	_____
Sisters	(Y) (N)	_____	_____
	(Y) (N)	_____	_____
	(Y) (N)	_____	_____
Brothers	(Y) (N)	_____	_____
	(Y) (N)	_____	_____
	(Y) (N)	_____	_____

**SOCIAL HISTORY:**

**SUBSTANCES**

**Tobacco Use**

Cigarettes  
 Quit: (Y) (N) Date \_\_\_\_\_  
 Currently: \_\_\_\_\_ packs/day # yrs \_\_\_\_\_  
 Other tobacco: (Pipe) (Cigar) (Snuff) (Chew)  
 Interested in quitting: (Y) (N)

**Alcohol Use**

Do you drink Alcohol? (Y) (N) # drinks/week \_\_\_\_\_  
 Is alcohol use a concern for you or others? (Y) (N)

**Drug Use**

Do you use recreational drugs? (Y) (N)  
 Have you ever used needles? (Y) (N)

**EXERCISE:**

Do you exercise regularly? (Y) (N)

**SOCIOECONOMICS:**

Occupation: \_\_\_\_\_  
 Education Completed: \_\_\_\_\_  
 Can you read: (Y) (N)  
 Marital status: (S) (M) (W) (D) \_\_\_\_\_  
 Number of children: \_\_\_\_\_  
 Who lives at home with you? \_\_\_\_\_

**SAFETY:**

Do you use seatbelts consistently? (Y) (N)  
 Is violence at home a concern for you? (Y) (N)  
 Do you feel safe in your current relationship? (Y) (N)  
 Other concerns? \_\_\_\_\_

**SEXUALITY**

Sexually Active: (Y) (N) (Not currently)  
 Birth Control Method: \_\_\_\_\_ or (N/A)  
 Have you ever had any STDs? (Y) (N)  
 If yes, please include: \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_ Date \_\_\_\_\_