

Gynecology/Pap Test Medical Review

Name: _____

Patient section: Please answer the following Questions. This will help your physician identify possible problems.

Your age: _____

When was your last mammogram? _____

When was your last period? _____

When was your last PAP test? 1 yr 2 yrs 3 yrs

Were the results normal? Yes No

Have you ever had an abnormal PAP test? Yes No

How often do you usually get your period? every ____ days

Are your periods usually regular? Yes No

How many days do your periods usually last? ____ days

The blood flow is: Light Moderate Heavy

Do you have any bleeding between periods? Yes No

Do you have any vaginal discharge? Yes No

Are you sexually active? Yes No

If yes, do you and your partner use birth control? Yes No

Method: _____

Have you ever had a sexually transmitted disease? Yes No

Has your mother ever been exposed to DES? Yes No

Have you ever used fertility medicines? Yes No

Do you have hot flashes? Yes No

Are you on hormone replacement? Yes No

Do you smoke? Yes No

How often do you perform self breast-exams? Less often than monthly Monthly

Do you have a history of breast problems? Yes No

Have you ever been abused? Yes No

Do you feel safe? Yes No

Is there any family history of:

Breast cancer? Yes No

Colon cancer? Yes No

Uterine cancer? Yes No

Ovarian cancer? Yes No

Other cancers? Yes No

Osteoporosis? Yes No

Heart disease? Yes No

Do you have any allergies? Yes No (list them below)

On a scale of 0 to 10, with 0 being no symptoms and 10 being severe symptoms, how would you describe the following (please circle):

Pain during your usual period: 0 1 2 3 4 5 6 7 8 9 10

Pain during sex: 0 1 2 3 4 5 6 7 8 9 10

PMS (premenstrual tension syndrome): 0 1 2 3 4 5 6 7 8 9 10

If you have been pregnant, please indicate how many:

Pregnancies _____ Full-term live births _____ Premature births _____ Abortions _____ Living children _____

Please list any other concerns: