



Women's Health For Life, Inc.

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GYNECOLOGY INFORMATION SHEET

Name				Age		Today's Date / /		
Why did you make this appointment?								
Family Physician			Marital Status M S D W			Insurance		
MEDICAL HISTORY				PREGNANCIES				
Have you ever had:		Yes	No	No.	Year	Months Pregnant	Type of Delivery	Problems
Heart disease				1.				
Lung disease				2.				
Kidney/Bladder disease				3.				
Seizure disorder				4.				
High blood pressure				5.				
Hyperlipidemia				Last Mammogram: / /			Normal?	Yes / No
Diabetes				Last Dexa Scan: / /			Normal?	Yes / No
Cancer				MENSTRUAL HISTORY				
Pelvic disease				Age periods started?			Regular? Yes / No	
Venereal disease				How often are your periods? Every			days.	
Tuberculosis				How long? days, from start to stop.				
Liver disease				Number of pads or tampons used each day?				
Blood disease				Pain with periods? Yes / No				
Mental illness				Spotting after intercourse? Yes / No				
Exposure to DES				Age of first sexual encounter?				
Drug dependency				Number of partners?				
Reaction to anesthetics				Are you using birth control? Yes / No				
Sexual abuse				Method?			Problems? Yes / No	
SURGICAL HISTORY				First day of last menstrual period?				
Year	Operation	City	Surgeon	Do you perform self breast exams?				
				PRESENT MEDICAL HISTORY				
				Do you feel you have problems with:		Yes	No	
				Ear, eyes, nose, throat, neck				
				Weight or appetite changes, infections				
MEDICATIONS (Name & Dosage)				Breathing or heart problems				
				Abdominal pain, bowel changes				
				Skin problems, joint or muscle aches				
				Memory loss or headaches				
ALLERGIES (reaction)				Menstrual periods/female organs				
				Breasts				
FAMILY HEALTH PROBLEMS (cancer, etc)				Energy/depression/weight/sleeping				
Father		Mother		Urinary symptoms				
Siblings				Abnormal bleeding				
Children				Hot flashes				
Grandparents				Hair growth				
How much do you smoke?				Pelvic pain with intercourse/sex life				
How much alcohol do you drink?				Marital problems				
Do you use IV or illegal drugs?				Date of last pap smear: / /		Normal? Yes / No		