NAME _____ DATE OF BIRTH _____ DATE _____

GYN HISTORY

Sexually Active Y / N

Birth Weight of Children _____

C-Section Y / N How many _____

Episiotomy Y / N How many _____

Forceps Delivery Y / N How many _____

Hysterectomy Y / N If Y, was it Vaginal Y / N Total _____ Partial _____

Painful Intercourse Y / N

Tear at Birth Y / N How many _____

Vaginal Births Y / N How many _____

Abnormal Pap Y / N

HPV Vaccine Y / N

Date of Most Recent Mammogram _____

Date of Most Recent Bone Density _____

Your Age at First Childbirth _____

Date of Last Pap Smear _____

Hormone Replacement Therapy Y / N

If Post Menopausal, Age at Menopause _____

STIs/STDs

Abnormal Pap Y / N If Yes, Please Explain

_____

_____

_____