FGCU GYNECOLOGICAL HISTORY: **NAME:(print)**__________________________________
Today's date:______________________ DOB:____________ Age________________
Home Phone_____________________ Phone (day): cell_______________________________

Last normal menstrual period (**first** day)________________ Menarche (age when periods began)________
Interval between periods:_________days; Length of period: ______days; Amt (Heavy, light)______________
Do you have regular periods?_________ Irregular periods? (interval varies, misses periods)____________

Abnormal bleeding? Yes___ No___ Describe____

Bleeding after intercourse?___________ Pain after or with intercourse?_____________________________

Abnormal vaginal discharge? Yes___ No___ Describe____

History of infection in uterus, tubes or ovaries? Yes___ No___ When?______________________________

Last pap smear_________________Have you ever had an abnormal pap smear (abnormal cells)?_________

Any pregnancies? No___ Number of pregnancies______ Children_____ Miscarriage_____Abortion_____
Are you concerned about being pregnant right now? Yes____ No_____

In the past, have you used any of the following contraceptive methods?

____ the pill ____________ Any problem with any of the methods?______________________
____ condom ____
____ the patch (OrthoEvra) ____
____ vaginal ring (Nuvaring) ____
____ DepoProvera injectable ____
____ pulling out or withdrawal ____
____ other________________ ____

Are you presently using any contraceptive method?____
If taking birth control pills now, what time do you take your pill (*which hours*)?_______________
Using abstinence now________________________ No method now____________________________________

Do you smoke? No____ Yes____ How much? (per day or week) __________________ per__________

Sexual history: Any sexual intercourse? (Ever) Oral___ Vaginal___ Anal____ Skin to skin___ None____
How long ***sexually*** with current partner?_____________ Last sex with a different partner_______________
Gender of partners: Male_____ Female_____ Both______ Date of last intercourse_________________
Number of partners in past 3 months_____ In past year______ In your lifetime________ (include oral sex)
Last unprotected intercourse (no condom)____________________ Age at **first** intercourse_________
Condom use: Always____ Most of the time____ Sometimes_____ None____ Start to finish? Y___ N___

HEALTH HISTORY:
Have **you** or any member of your immediate family had cancer, thyroid, heart disease, migraines, diabetes, stroke or other blood clots, liver disease or high cholesterol? (Circle all that apply) Yes____ No_____
Who? Please explain: ____
____

List medications:____
(Include nasal sprays, eye drops, inhalers, herbals, vitamins, over-the-counter used regularly, BC method)