Gynecological History Form

Today's date: Year 20____ Month ____ Day ____

Name: ____________________

Age: ________ years old

1. When was the first day of your last menstrual period?	Start day: Month ____ Day ____ Duration: ______ days ☐Unknown	☐ I am pregnant (including positive pregnancy test) ☐ I am breastfeeding ☐ Age at menopause: ________
2. When was the first day of your period before the one above?	Start day: Month ____ Day ____ Duration: ______ days ☐Unknown	

What would you like to discuss with your doctor today?
Please place a ✔ in the appropriate ☐ and give us details in the column on the right.

☐ Pregnancy	Please pick up an "Obstetrical History Form" at the front desk.	
☐ Menstrual period (Please be specific)	☐Menstrual pain ☐Heavy bleeding ☐Bleeding with clots ☐Premenstrual syndrome	
	I am taking medications	Pain relief medicine: ( ) Kampo (traditional herbal medicine): ( ) Other: ( )
☐ Abnormal vaginal bleeding	☐Before my period ☐Several days after my period ☐Other	
☐ Abnormal vaginal discharge	☐Heavy ☐Odor/smell ☐Change in color: ( )	
☐ Abdominal / lower back pain	☐During my period ☐Before my period ☐Not related to my period ☐During sexual intercourse ☐During bowel movements ☐During urination ☐Comes and goes (Please explain below): ( )	
☐ Abnormalities of the vulva/vagina	☐Itching ☐Pain ☐Sores/bumps ☐Discomfort	

☐ Fertility treatment	Did not use birth control for: ______ years and ______ months
☐ Menopause	Please explain:
☐ Contraceptives (Birth control)	☐ Emergency contraception (date & time of sexual intercourse: Month ___ Day ___ Time ___) ☐ Birth control pills ☐ IUD (Intrauterine Device)
☐ Delaying/preventing menstrual periods	I want to avoid having my period: From Month ___ Day ___ ～ To Month ___ Day ___

☐Gynecological examination / check	☐Cervical cancer (entrance to the uterus) ☐Uterine cancer (inside the uterus)
☐Sexually Transmitted Diseases (STD) test	☐Chlamydia ☐Syphilis ☐Gonorrhea ☐HIV ☐Hepatitis B ☐Other: ( )

☐Abnormalities found at another health facility or during health check-ups	Please explain: Name of the health facility: ( )

☐Other	

Name: ________________________________
Height: ________cm Weight: ________kg
*If you are pregnant, write your usual weight

● Menstrual Period

Menstrual cycle	Cycle length: ~____days (first day of your period to the first day of your next period) Duration of bleeding: ____days Interval: ☐Regular ☐Irregular Menstrual flow / bleeding: ☐Light ☐Moderate ☐Heavy Symptoms: ☐Abdominal pain ☐Headache ☐Lower back pain		
Age at first period	years old	Age at menopause	years old

● Pregnancy History

Past pregnancies: _____times ・ Delivery: ______times ・ Miscarriages: ______times
Abortions: _______times ・ Other: ____

#	Delivery Date Year/Month/Day	Your age	Weeks	Birth Weight	Sex	Baby is healthy	Type of Delivery	Miscarriage Abortion Ectopic	Place of Delivery
1	_____ /___ /___			g	☐M ☐F	☐Yes ☐No	☐Vaginal ☐Cesarean ☐Vacuum/Forceps		
2	_____ /___ /___			g	☐M ☐F	☐Yes ☐No	☐Vaginal ☐Cesarean ☐Vacuum/Forceps		
3	_____ /___ /___			g	☐M ☐F	☐Yes ☐No	☐Vaginal ☐Cesarean ☐Vacuum/Forceps		
4	_____ /___ /___			g	☐M ☐F	☐Yes ☐No	☐Vaginal ☐Cesarean ☐Vacuum/Forceps		
5	_____ /___ /___			g	☐M ☐F	☐Yes ☐No	☐Vaginal ☐Cesarean ☐Vacuum/Forceps		

Any pregnancy-related complications in the past:
☐High blood pressure ☐HELLP Syndrome ☐Seizures ☐Massive bleeding ☐Placenta abnormalities
☐Gestational Diabetes ☐Other:_____________________

● Gynecological and Medical History

☐Uterine fibroids ☐Endometriosis ☐Adenomyosis ☐Abnormal uterus shape ☐Ovarian tumor
☐Sexually transmitted disease (STD) ☐Other: ________________________________

☐Hypertension (high blood pressure) ☐Diabetes ☐Kidney disease ☐Heart disease ☐Thyroid disease
☐Hepatitis (liver inflammation) ☐Autoimmune disease ☐Asthma (write date of last episode below)
☐Cancer ☐Stroke ☐Cerebral hemorrhage (bleeding in the brain) ☐Seizures ☐Mental/psychiatric illness
☐Glaucoma ☐Blood disease ☐Thrombosis (blood clot) ☐Other: ________________________

Please give details about the items you checked✔ above.

☐Hospitalization ☐Surgery ☐Blood transfusion	

● Other

☐Alcohol (_______ times / week) ☐Smoking (_______ cigarettes / day)
☐Current medications:

● Family History

*Please write relationship to you in the ( ). Example: ☑Cancer (grandfather-stomach, father-lung)

☐High blood pressure ( ) ☐Diabetes ( )
☐Venous thromboembolism (blood clot in the vein) ( )
☐Blood disease (such as hemophilia) ( ) ☐Cancer ( )
☐Other hereditary diseases ( )

Physician's signature: