The Corvallis Clinic™
PHYSICIANS & SURGEONS

Date: .....

Gynecology History

Name: ..... Occupation: .....

Age: ..... ☐single ☐married ☐widowed ☐separated ☐divorced ☐partnered

Reason for Visit: .....

Are you using contraception? ☐Yes ☐No If yes, what method. (pill, vasectomy, etc.) .....

Menstrual History (skip if menopausal or had hysterectomy)

Age of first menses: .....

Date last menstrual period started .....

Date last normal menstrual period started .....

Cycle ..... days (start to start)

How many days do your periods last? ..... days

Are your periods painful? ☐Yes ☐No Do you have vaginal bleeding between periods? ☐Yes ☐No

GYN History

Date of last pap smear: ..... Any history of abnormal pap smears? ☐Yes ☐No

Any history of sexually transmitted disease? ☐Yes ☐No

Is intercourse painful? ☐Yes ☐No Is there vaginal bleeding after intercourse? ☐Yes ☐No

How many times a week do you leak urine? ..... Date last cholesterol? .....

Date of last mammogram? ..... Date last colon cancer screening (colonoscopy/flex sig)? .....

OB History

Please list all pregnancies, including miscarriages, ectopics and terminations:

Year	Infant Weight	Sex	Complications	Where Delivered
1.				
2.				
3.				
4.				

What medications are you allergic to? .....

What medications are you taking? (include vitamins and herbal products) .....

.....

Please list Medical Problems: .....

.....

Please list past surgeries: .....

.....

How many cigarettes smoked per day? ..... How many alcoholic drinks per week? .....

When was your last tetanus shot? ..... Recreational drugs? .....

Current height: ..... Current weight: ..... Weight 2 years ago: .....

Has any blood relative had: (circle and who)

High blood pressure Heart problems Diabetes Cancer of the: ovary, breast, uterus, colon

(please complete back side)

OB/GYN 3680 NW Samaritan Drive
Corvallis, OR 97330 (541) 754-1267
MD1384 (09/10) **progress notes**

Name .....

Patient ID# .....