Patient name: _____
Date of birth: _____

BAPTIST HEALTH®
MEDICAL GROUP

GYNECOLOGIC AND OBSTETRIC HISTORY

Date of last menstrual period: _____

Are your cycles regular? ❑Yes ❑No Do you bleed between periods? ❑Yes ❑No

How long do your periods last?_____days

How many days after a period begins will the following period start? _____days

Are you currently sexually active? ❑Yes ❑No

With men? ❑Yes ❑No ❑N/A With women? ❑Yes ❑No ❑N/A

Are you currently sexually active with only one person? ❑Yes ❑No

Number of lifetime sexual partners:_____ Does your partner always use a condom? ❑Yes ❑No

Current birth control (including tubal or vasectomy):_____

When was your most recent Pap smear?_____ When was your most recent mammogram? _____

Does your family have a history of cancer, especially breast, ovarian, colon and/or uterine cancer? ❑Yes ❑No

If yes, please state family member and type of cancer: _____

Have you ever had any of the following, now or in the past?

Sexually transmitted disease ❑Yes ❑No Ovarian cysts ❑Yes ❑No

Sexual or physical abuse ❑Yes ❑No Tubal infections ❑Yes ❑No Endometriosis ❑Yes ❑No

Uterine fibroids ❑Yes ❑No Abnormal Pap smear ❑Yes ❑No Tubal pregnancy ❑Yes ❑No

Total number of times: Pregnant _____ Deliveries_____

Number of living children_____ Miscarriages_____ Abortions_____

Please list previous deliveries:

Date	Type of delivery (vaginal or C/S)	Term / preterm	Birth weight	Child's name	Child's father's name	Complications of pregnancy or delivery