

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

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