GynoFit MD
Women's Health & Medical Weight Loss Expert

Gynecology Medical History Form

Name:_____ DOB:_____ Age:_____

Race:_____ Marital status: **Never Married / Married / Divorced /Legally Separated / Widowed**

Reason for your visit:_____

Other concerns:_____

MENSTRUAL HISTORY

1. Last menstrual period:
2. Number of days between cycles:
3. Age of first menstrual period:
4. Flow amount:
5. Current birth control:
6. Have you had a tubal ligation?:

PREGNANCY HISTORY

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

SURGICAL HISTORY

Surgery Type: _____ Date: _____

SOCIAL HISTORY

Occupation: _____

Have you ever been or currently are sexually active?	☐ Yes	☐ No	
Did you have more than one sexual partner in the last year?	☐ Yes	☐ No	
Have you ever smoked or currently smoke cigarettes or tobacco?	☐ Yes	☐ No	Amount per day: If former smoker, age quit:
Do you use recreational or illicit drugs?	☐ Yes	☐ No	Type: Frequency:
Do you drink alcohol?	☐ Yes	☐ No	Amount per day: If former drinker, age quit:
Have you ever been physically or sexually abused?	☐ Yes	☐ No	

GYNECOLOGY MEDICAL HISTORY

Last Pap Smear: _____	Result: _____	
Have you ever had an abnormal pap smear? _____	Date: _____	Treatment received: _____
Last mammogram: _____	Result: _____	Performed at: _____
Last bone density: _____	Result: _____	

ALLERGIES

Allergy	Reaction

If you have no known allergies, please circle: **NO ALLERGIES** Latex Allergy: **YES / NO** Iodine Allergy: **YES / NO**

MEDICATIONS

Medication Name	Dose	Frequency	Taken For	Date Started

NUTRITION & PHYSICAL ASSESSMENT

Check your current experiences (check all that apply):

Late night snacking Food cravings Large portions Emotional eating

Exercise: Circle YES OR NO

Yes: Type of exercise: _____ How many times per week: _____

No: What keeps you from exercising?_____

Rate your willingness: On a scale of 0-10, rate your willingness to make dietary and lifestyle changes for weight loss? (0 = 0% willing and 10 = 100% willing)

0 1 2 3 4 5 6 7 8 9 10

Rate your confidence: On a scale of 0-10, rate your confidence in your ability to make changes required for weight loss? (0 = 0% willing and 10 = 100% willing)

0 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Check all that apply:

Condition	Age of Diagnosis	Date of Treatment	Treatment
Heart Disease			
Hypertension			
Heart Disease			
Neurological Disorders			
Stroke			
Respiratory			
Asthma			
Sleep Apnea			
Hematologic			
Clotting Disorders/Blood Clot Leg/Lung			
Bleeding Disorders			
Anemia (Thalessemia, Sickle Cell)			
Endocrine/Metabolic			
Diabetes			
Thyroid Disease			
Cancer			
Gynecological Infections			
History of STI:			

Condition	Age of Diagnosis	Date of Treatment	Treatment
Gynecological Conditions			
☐ Abnormal bleeding			
☐ Uterine fibroids			
☐ PCOS			
☐ Endometriosis			
☐ Ectopic pregnancy			
☐ Ovarian cyst			
☐ Infertility			
Auto Immune Disorders			
☐			
Mental Health			
☐			

FAMILY HISTORY (Please list family members diagnosed, if any:)

Condition	Family Member/Relative	Age of Diagnosis	Treatment
Heart Disease			
☐ Hypertension			
☐ Heart Disease			
Neurological Disorders			
☐ Stroke			
Hematologic			
☐ Clotting Disorders/Blood Clot Leg/Lung			
☐ Bleeding Disorders			
Endocrine/Metabolic			
☐ Diabetes			
☐ Thyroid Disease			
Cancer:			
Gynecological Infections			
☐ No infections			
☐ History of STI			
Gynecological Conditions			
☐ Uterine fibroids			
☐ PCOS			
☐ Endometriosis			
Auto Immune Disorders			
☐			
Mental Health			
☐			

Patient Name (print): _____

Patient Signature: _____ Date: _____