GYNECOLOGICAL RECORD

Date _____

Contact @ Home _____

Name_____ Birth Date_____Age_____

Address _____Phone_____Business Phone_____

Patient's Business Address _____Occupation_____

Husband's Name_____Business Address_____Occupation_____

Number of Live Births_____ Miscarriages or Abortions _____ First Day of Last Menstrual Period _____ First Day of Previous Menstrual Period_____Last Pap _____

Age of First Menses _____ Menses reg/irreg. _____Cramps _____ Flow_____ Clots _____

History:

___Measles	___Rheumatic Fever	___Seizures	___Heart Disease
___German Measles	___TB	___Asthma	___Urinary Tract Infection
___Chicken Pox	___Hepatitis	___Diabetes	___Blood Transfusions
___Mumps	___Jaundice	___High Blood Pressure	___DES Exposure
___Pelvic Inflammatory Disease	___Migraines	___Cancer	___Thrombophlebitis
___Smoker	___Herpes	___Thyroid Problems	___Substance Abuse

Operations: _____

Allergies (indicate manifestations): _____

Contraceptive History

Present Method: _____

Past Methods: _____

_____

_____

Current Problems

_____

_____

_____

_____

Current Medication

_____

_____

_____

_____

Family History:

Twins_____Congenital Anomalies _____

Diabetes_____ Hereditary Disorders_____

Husband: Age_____ Height_____ Weight _____Blood Type & Rh _____

Father: Living _____ Deceased_____ Age_____ Mother: Living _____ Deceased_____ Age_____

Brother(s): Living _____ Deceased_____ Age_____ Sister(s): Living _____ Deceased_____ Age_____

Previous Pregnancies

Name	Date	Weeks	Sex	Birth Weight	Complications of Pregnancy	Length of Labor	Complications of Labor	Anesthesia	Baby Diet	Post-Partum Complications

Abortions

Date	Weeks	Spontaneous or Induced	Operation	Complications

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