MHC Healthcare
Quality healthcare with a heart!

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CONFIDENTIAL GYNECOLOGY HISTORY

		YES	NO
1.	Please indicate your present method of birth control. None, or ________________________		
2.	Do you think you might be pregnant?	☐	☐
3.	Your last menstrual period began on_______/______/ _____		
4.	Write in any changes related to your period:________________________		
5.	Have you noticed any unusual vaginal odor, discharge, or itching?	☐	☐
6.	Are you sexually active? If yes, how many partners have you had in the past year?__________ If yes, do you have pain during intercourse? Y / N	☐	☐
7.	How would you describe your sexuality? (**circle one**) Heterosexual Lesbian Bisexual Not Sexually Active		
8.	Are you worried you might have a sexually transmitted disease?	☐	☐
9.	Have you ever been diagnosed with Gonorrhea, Chlamydia, Herpes, Syphilis, or HIV(AIDS)? If yes, when and where were you treated? ________________________	☐	☐
10.	Have you found any abnormalities while examining your breasts?	☐	☐
11.	Have you ever had an abnormal finding on a mammogram? Date and place of last mammogram ________________________	☐	☐
12.	Have you had a pelvic ultrasound done within the last 12 months? If yes, date and place of ultrasound ________________________	☐	☐
13.	Since your last visit have you had any recent operations, serious illnesses, or injuries? If yes, describe________________________	☐	☐
14.	Are there any other problems you would like to discuss with me? If yes, describe________________________	☐	☐
15.	Please list the Pharmacy of your choice if a prescription is needed: ________________________		