Salmonberry Birth and Wellness
Serving Port Angeles, Sequim and Joyce, WA

www.gentlegyne.com

Cheri Shields, ARNP, CNM

Phone (360) 775-9486
cheri@gentlegyne.com

GYNECOLOGY HISTORY FORM – PAGE 1 OF 2

NAME: _____ DOB: _____ AGE: _____ Today's Date: _____

Reason for visit (current concerns): _____

MEDICATIONS: (List all, including dose if you know it. Please include vitamins, supplements, and over-the-counter medications): _____
_____
_____

ALLERGIES: _____

GYNECOLOGIC HISTORY:
Age at first period: _____ First day of your last period: _____ Cycle length: _____ (days)
# of days of flow: _____ Excessive bleeding? Y N Excessive cramping? Y N
Other problems related to your period? _____

Date of your last pap: _____ History of abnormal paps? Y N
If yes, Describe: _____

Date of last mammogram: _____ History of abnormal mammograms? Y N
If yes, Describe: _____

Please check any you have had:
❑ Herpes ❑ HPV ❑ HIV ❑ Genital Warts ❑ Syphilis ❑ Chlamydia ❑ Trich ❑ Gonorrhea

FAMILY PLANNING AND BIRTH CONTROL:
Do you want to become pregnant? Y N
Are you using any type of contraception? Y N If yes, what kind? _____

Please check any past contraceptive methods you have tried:
❑ Condoms ❑ Birth control pills ❑ Depo Provera shot ❑ Nexplanon ❑ Patch ❑ Paragard/Copper IUD
❑ NuvaRing ❑ Hormonal IUD (Mirena/Kyleena/Skyla/Liletta) ❑ Fertility Awareness ❑ Other: _____
Comments: _____

PREGNANCY HISTORY:

#	Date	Wks at delivery	Delivery Type*	Baby weight	Sex	Complications
1						
2						
3						
4						
5						
6						

**Vaginal, C-Section, Miscarriage or Abortion*

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GYNECOLOGY HISTORY FORM – PAGE 2 OF 2

PERSONAL AND FAMILY MEDICAL HISTORY (please check all that apply):

	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF	Other
Heart Disease / Heart Attack									
Stroke									
Diabetes									
High Blood Pressure									
High Cholesterol									
Thyroid Disease									
Breast Cancer									
Ovarian Cancer									
Other Cancer									
Asthma									
Blood Clot or Bleeding Disorder									
Endometriosis									
Infertility									
Intestinal Problems									
Bladder or Kidney Problems									
Lupus									
Migraines									
Seizures or Epilepsy									
Eating Disorder									
Depression and/or Anxiety									
Substance or Alcohol Use Disorder									
Birth Defects									
Other:									
Other:									

SURGERIES or hospitalizations (procedure and year): _____
_____
_____

SOCIAL HISTORY
Ethnicity: _____ Occupation: _____
Relationship status: _____ Sexual orientation: _____ Gender identity: _____
Partner's name (if applicable): _____ Partner's Occupation: _____
How many sexual partners have you had in the last year? _____ In your lifetime? _____
Do you feel safe in your current relationship?: Y N

How many alcoholic drinks do you have a day? _____ A Week? _____ Type? _____
Are you a current smoker? Y N # Cigarettes per day: _____ Former smoker? Y N Quit date _____
Current E-Cigarette Use? Y N
Do you use drugs or take non-prescribed pills? Y N If yes, what kind? _____

How many times a week do you exercise? _____ Do you wear a seat belt? Y N