## **Women's Health Gynecological History Form**

## **Personal Information**

Full Name	
Date of Birth	
Phone Number	
Email Address	
Gynecological History	
Age at first period	
Date of last period	
Date of last period	
Are your periods regular?  Ves	
C No	
If no, please explain	
Cycle length (days)	
Bleeding duration (days)	
A 11 1' 1 1 0	
Any bleeding between periods?  C Yes	
C No	
Pain with periods?  Yes	
C No	

Obstetric History  Number of pregnancies  Number of births  Number of miscarriages  Number of abortions  Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  No  History of sexually transmitted infections (STIs)?  Yes  No  No  f yes, details	f yes, severity or comments	
Number of pregnancies  Number of births  Number of miscarriages  Number of abortions  Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No		
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Number of abortions  Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No		
Number of abortions  Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No	Number of miscarriages	
Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No	Tanisar of missarringer	
Any complications?  Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No		
Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No	Number of abortions	
Contraception & Sexual Health  Current contraception method  Are you sexually active?  Yes  No  History of sexually transmitted infections (STIs)?  Yes  No		
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Are you sexually active?  Yes  No History of sexually transmitted infections (STIs)?  Yes  No		
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Are you sexually active? Yes No History of sexually transmitted infections (STIs)? Yes No	Contraception & Sexual Health	
Are you sexually active? Yes No History of sexually transmitted infections (STIs)? Yes No	Current contracention method	
Yes No History of sexually transmitted infections (STIs)? Yes No	Surenic contraception method	
Yes No History of sexually transmitted infections (STIs)? Yes No		
Yes No History of sexually transmitted infections (STIs)? Yes No	Are you sexually active?	
History of sexually transmitted infections (STIs)?  Yes  No		
C Yes  No		
○ No	History of sexually transmitted infections (STIs)?	
	∪ Yes	
	○ No	
	○ No	
	○ No	

## **Medical History**

Previous gynecological surgeries or procedures

Any known gynecological conditions? (e.g., endometriosis, fibroids, PCOS)	
Last Pap smear date	
Last mammogram date	
Other relevant medical history	
Family History	
Family history of reproductive cancers?	
C Yes	
No If yes, please specify	
III you please opening	
Other relevant family history	
Comments / Additional Information	