FRANK BONURA, M.D., P.C.

GYNECOLOGICAL HISTORY FORM

DATE__________________

NAME______________________________________DOB____________AGE_______

HAVE YOU EVER BEEN PREGNANT? YES______NO______

HOW MANY PREGNANCIES?_______TERMINATIONS OF PREGNANCY?______

MISCARRIAGES?______PREMATURE BIRTHS?______LIVING?______

DO YOU GET A PERIOD? YES______NO______

IF YES, WHEN WAS YOUR LAST PERIOD? __________________

ARE YOUR PERIODS REGULAR? YES______NO______

ARE YOUR PERIODS HEAVY? YES______NO______

ARE YOU MENOPAUSAL? YES______NO______

IF YES, WHAT AGE DID YOUR PERIOD STOP? AGE______________

DID YOU HAVE A HYSTERECTOMY? YES_____NO_____

DO YOU GET HOT FLASHES? YES______NO______

NIGHT SWEATS? YES______NO______

INSOMNIA? YES______NO______

VAGINAL DRYNESS? YES______NO______

VAGINAL OR VULVUL ITCHING? YES______NO______

HAVE YOU HAD A FLU SHOT? YES_____, WHEN? ______NO______

PNEUMONIA SHOT? YES_____, WHEN? ______NO______

COLONOSOPY YES_____, WHEN?______NO______

WHAT MEDICAL PROBLEMS DO YOU HAVE?

HIGH BLOOD PRESSURE	YES_____	NO_____
DIABETES	YES_____	NO_____
THYROID DISEASE	YES_____	NO_____
HEART DISEASE	YES_____	NO_____
RESPIRATORY PROBLEMS	YES_____	NO_____
LIVER PROBLEMS	YES_____	NO_____
KIDNEY DISEASE	YES_____	NO_____
BLOOD PROBLEMS	YES_____	NO_____
ARTHRITIS	YES_____	NO_____
OSTEOPOROSIS	YES_____	NO_____
OTHER	YES_____	NO_____

EXPLAIN____

HAVE YOU HAD ANY OPERATIONS? YES_____ NO_____
LIST OPERATIONS: ____

____

____

ARE YOU TAKING ANY MEDICATIONS? YES_____ NO_____
LIST MEDICATIONS: ____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES_____ NO_____
LIST MEDS.____

WHEN WAS YOUR LAST PAP TEST? _______________
WAS IT NORMAL? YES_____ NO_____

WHEN WAS YOUR LAST MAMMOGRAM? _______________
WAS IT NORMAL? YES_____ NO_____

ARE YOU SEXUALLY ACTIVE? YES_____ NO_____

IF YES, DO YOU HAVE PAIN WITH INTERCOURSE? YES_____ NO_____

IF YES, DO YOU AND YOUR PARTNER
USE BIRTH CONTROL? YES_____ NO_____

IF YES, WHAT METHOD?____

DO YOU SMOKE? YES_____ HOW MUCH? _____ NO_____

ALCOHOL? YES_____ NO_____ SOCIALLY_______

IS THERE A FAMILY HISTORY OF:

BREAST CANCER	YES_____	NO_____	EXPLAIN______________
COLON CANCER	YES_____	NO_____	EXPLAIN______________
UTERINE CANCER	YES_____	NO_____	EXPLAIN______________
OVARIAN CANCER	YES_____	NO_____	EXPLAIN______________
OTHER CANCERS	YES_____	NO_____	EXPLAIN______________
HEART DISEASE	YES_____	NO_____	EXPLAIN______________
OSTEOPOROSIS	YES_____	NO_____	EXPLAIN______________
HIP FRACTURE IN MOTHER OR FATHER	YES_____	NO_____	EXPLAIN______________

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PLEASE CHECK OFF YOUR ANSWER

1. **Do you leak urine when you cough, sneeze, lift or exercise?**
   _____Yes _____No

2. **Do you leak urine without warning?**
   _____Yes _____No

3. **Do you ever have sudden urges to urinate?**
   _____Yes _____No

4. **Do you sometimes wear protective pads or diapers for loss urine?**
   _____Yes _____No

5. **How many times do you urinate while awake during the day?**
   Day _______times

6. **Do you wake up during the night to urinate?**

   _____Yes _____No

   How many times______

NAME: ____

DATE: ____