**GYN History**

Name: Date of Birth:

Address: City State Zip

Cell Phone: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: ID#

Policy Holder Group #

Policy Holder SSN# Policy Holder DOB

Emergency Contact: Relationship:

Emergency Contact Phone:

First Day of Last menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **CURRENT PRESCRIPTIONS and OVER THE COUNTER MEDICATIONS** |
| Name of Medication | Dosage (total mg) | Number per day | Prescribing Doctor | Reason for medication | Side effects? |
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|  |  |  |  |  |  |

Surgeries in the Past Year:

Hormonal Related Issues:

Family History Changes:

Any additional concerns or changes to your medical history in the past year: