CUMMINS
women's health + wellness

GYNECOLOGIC ASSESSMENT FORM

Name _____ **Preferred Name** _____ **DOB:** _____

Date of Visit: _____ **Reason for Visit:** Routine Wellness Check ____ Problem ____

Describe Problem: _____

Gynecologic History

Average days between cycles		Sexual Orientation	
Average duration of flow		Sexually Active (current/past/never)	
Number of heavy flow days		Method of Birth Control	
Pain with Cycle		History of Abnormal Pap Smears	
Age of Menopause		History of Colposcopies	
Bleeding after Menopause		History of STIs	

Pregancy Summary (please list the total number for each, if none, leave blank)

	Number		Number		Number
Total Pregnancies		Vaginal Deliveries		Cesarean Sections	
Miscarriages		Abortions		Ectopic	

Preventative Care (please list the year of your most recent of each below; if it doesn't apply, list NA)

	Year		Year		Year
Pap Smear		Colonoscopy		HPV Vaccine	
Mammogram		Bone Density		Pelvic Ultrasound	

Current Medications (including OTC, supplements, vitamins, etc.)

Allergies to Medications

Personal Medical History (please check all that apply)

High Blood Pressure		Autoimmune Disorder		Asthma	
Diabetes		CVA/TIA/Stroke		Acid Reflux	
Thyroid Disorder		Cancer		High Cholesterol	
Migraines		Osteoporosis/Osteopenia		Seizure Disorder	
Blood Clots (DVT/PE)		Heart Disease (MI)		Anxiety/Depression	

Surgical History (please list the type and year of all surgeries done)

Family History (first- and second-degree relatives only)

Cancer or Other Major Illness	Relative

Social History

Marital Status		Occupation	
Average Exercise/week		Caffeine (amount/day)	
Tobacco/E-cig (amount/day)		Alcohol (amount/day)	
Illicit Drug Use (current/past)		History of Emotional/ Physical/ Sexual Abuse	