



Moore for Women Healthcare & Wellness

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GYNECOLOGIC HISTORY

DATE: _____

Patient Name: _____ DOB: _____

What is the reason for you visit?

1. Number of pregnancies? _____ Number of babies you've had? _____
2. What is your current method of birth control? _____ Any problems?

3. Date of your last pap smear?

4. Have you ever had an abnormal pap? _____ If yes, how was it treated?

5. Date of your last mammogram _____ Any abnormality?

6. Have you ever had ant osteoporosis screening?

7. Check if you currently have:
 Unusual Vaginal Discharge Pain with urination Genital sores Severe
Leg pain
 Vaginal itching or burning Severe abdominal pain Severe headaches
Pain/bleeding with intercourse

MENSTRUAL HISTORY

If you have undergone menopause ("Change of life") skip to question # 15.

8. First day of your last menstrual
period _____
9. Are your periods usual regular? _____ every _____ days, lasting _____
days
10. Do you have pain with your periods?

11. Do you take medication for painful periods?

12. Have your periods changed recently?

13. Have you had any bleeding between periods?

14. Age at your first period? _____
15. Have you undergone menopause? _____
If yes, when was your last period?

Have you had any vaginal bleeding since then?

16. Do you have contact bleeding or bleeding during intercourse?

MEDICAL HISTORY

17. Have you ever had any operations or anesthesia (put to sleep) what & when?

18. Check below if you've ever had:

- Blood clots/Phlebitis Diabetes Abnormal pap smear
- High blood pressure Pelvic infection/PID Breast disease/Mumps
- Genital herpes Hepatitis/liver disease Chlamydia
- Syphilis Frequent Urine infection Cancer
- Gonorrhea Genital Warts (condyloma) AIDS

19. Are you currently taking any medications? (including vitamins) yes no If yes, what?

20. Are you allergic to any medicines? yes no If yes, what?

21. Do you have any other serious health problems?

SOCIAL & OCCUPATIONAL HISTORY

22. What is your occupation?

23. Do you smoke? yes no If yes, how much per day? _____

24. Do you exercise regularly? yes no If yes, how often? _____ How long? _____

25. Do you have an eating disorder? _____

26. Do you use alcohol? yes no If yes, how often? _____

27. Do you use "street" or recreational drugs?

FAMILY HISTORY

28. Did your mother take any hormones (DES) while pregnant with you?

29. Check below if anyone in your family ever had:

- Heart attack (under 50) Diabetes breast cancer
- High blood pressure Stroke (under age of 40) Uterine cancer

30. Any other major family health problems?

31. Do you have any questions or concerns?
