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GYNAECOLOGICAL HISTORY FORM

Date

PERSONAL DETAILS

Name
Date of Birth
Marital Status
Occupation
Religion

GP DETAILS

Referring GP
Usual GP

PRESENTING PROBLEM AND DURATION

MEDICAL HISTORY

Do You Currently Take The Pill?
If Yes - Name?
Regular Cycle?
Length of Cycle
Days Bleeding
Age at Menopause
Last Mammogram
Last Pap Smear
Normal Result?
If No - Details
Result and Treatment
Details of Previous Gynae Ops?

Have You Ever Suffered From :
- Herpes ☐
- HIV ☐
- Genital Warts ☐
- Hepatitis B ☐
- Hepatitis C ☐
- Chlamydia ☐
- Other ☐

Details of Prior Pregancies

General Medical Problems
Other Operations
Smoker?
Known Allergies
Current Medications
Family History of Breast, Ovarian, Uterine or Bowel Cancer?
If Yes - Details
Hereditary Medical Conditions?
Details
Any Other Relevant Information?