OB/GYN HISTORY FORM

Name	Date of Birth	Age	Date
With whom may we discuss test results or therapies?			

Past Obstetrical History – deliveries, miscarriages, ectopics, and abortions.

Date (Mo./Yr.)	1	2	3	4	5	6
Birth Weight						
Type of delivery (Vaginal/C-sect.)						
Complications						

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No Lifetime sexual partners (#)
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Age of 1st period	Birth Control Method
Last menstrual period	Age at Menopause
Length of periods (days)	Bone Density ☐ Yes – when ☐ No
Cramps? Mild / Mod / Severe / None	Osteopenia ☐ Yes ☐ No Osteoporosis ☐ Yes No
Number of days between periods	Last Colonoscopy

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Genital Warts/HPV ☐ Syphilis ☐ HIV ☐ Trichomonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Thyroid ☐ Skin ☐ Other

Allergies – List Reaction	Medications & Dosage – Include Vitamins / Herbs

CONTINUE ON BACK SIDE

Reviewed by (Signature of Provider) _____ Date _____

Past Medical History – Do you have any of the following:

Diabetes ☐ Yes ☐ No Comments	Kidney Disease/UTI ☐ Yes ☐ No Comments	Blood Clots Leg/Lung ☐ Yes ☐ No Comments
High Blood Pressure ☐ Yes ☐ No Comments	Stroke ☐ Yes ☐ No Comments	Neurologic/Epilepsy ☐ Yes ☐ No Comments
Heart Attack/Disease ☐ Yes ☐ No Comments	Thyroid Dysfunction ☐ Yes ☐ No Comments	Gastrointestinal ☐ Yes ☐ No Comments
Rheumatic Fever ☐ Yes ☐ No Comments	Tuberculosis ☐ Yes ☐ No Comments	Hepatitis/Liver Disease ☐ Yes ☐ No Comments
Mitral Valve Prolapse ☐ Yes ☐ No Comments	Asthma ☐ Yes ☐ No Comments	Gallbladder ☐ Yes ☐ No Comments
Psychiatric ☐ Yes ☐ No Comments	Anesthesia Complications ☐ Yes ☐ No Comments	Other ☐ Yes ☐ No Comments

Immunization History

Have you had a flu vaccine? ☐ Yes ☐ No	If yes, when?_____	
Have you been vaccinated against Hepatitis B? ☐ Yes ☐ No	If yes, when?_____	
Have you received Gardasil vaccine? ☐ Yes ☐ No	If yes, when?_____	
Have you been vaccinated against Pneumonia? ☐ Yes ☐ No	If yes, when?_____	
Have you been vaccinated against Tetanus? ☐ Yes ☐ No	If yes, when?_____	
Have you had chicken pox? ☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had Rubella (German Measles)? ☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had a PPD (Tuberculosis) skin test? ☐ Yes ☐ No	If yes, ☐ positive or ☐ negative	

Surgeries or Hospitalizations (Reason & Year)		
1	5	9
2	6	10
3	7	11
4	8	12

Family History – Does your family have any of the following:

Breast Cancer ☐ Yes ☐ No Which relative:	Other Cancers ☐ Yes ☐ No Which relative:
Ovarian Cancer ☐ Yes ☐ No Which relative:	Birth Defects/Hereditary Disorders ☐ Yes ☐ No Which relative:
Uterine Cancer ☐ Yes ☐ No Which relative:	High Blood Pressure ☐ Yes ☐ No Which relative:
Colon Cancer ☐ Yes ☐ No Which relative:	Heart Disease ☐ Yes ☐ No Which relative:
Osteoporosis ☐ Yes ☐ No Which relative:	Diabetes ☐ Yes ☐ No Which relative:
Gynecological Problems ☐ Yes ☐ No Which relative:	Psychiatric Disorder ☐ Yes ☐ No Which relative:

Social History

Occupation	Marital Status ☐ Widowed ☐ Single ☐ Married ☐ Divorced	Social Drug Use ☐ Yes ☐ No Type: Amount: How Often:
Cigarettes ☐ Yes ☐ No For how long:	Pack/Day: Quit date:	Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship
Alcohol ☐ Yes ☐ No Amount:	Type: How often:	Advance Directives ☐ Yes ☐ No If yes, please bring copy for your chart. ☐ Yes ☐ No

Review of Systems (Check all that apply) – Negative except where noted below:

Constitutional ☐ Weight Loss ☐ Fever ☐ Fatigue ☐ Other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ Urinary frequency/urgency ☐ Caffeine/day ☐ Other
Neck ☐ Pain ☐ Difficulty swallowing ☐ Lumps ☐ Other	Skin/Breast ☐ Rash ☐ Lumps in breast ☐ Nipple discharge ☐ Pain in breast ☐ Other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ Other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ Other
Respiratory ☐ Cough ☐ Pain with breathing ☐ Shortness of breath ☐ Other	Lymphatic ☐ Lumps in groin, under arms, or in neck ☐ Other

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HEALTH QUESTIONNAIRE

Do you have any of the following:

MEDICAL HISTORY

- ❑ Decreased hearing
- ❑ Ringing in ear
- ❑ Ear infections - *frequent*
- ❑ Fainting spells
- ❑ Failing Vision ❑ Eye pain
  Date of last eye exam _____
- ❑ Double or blurred vision
- ❑ Nose bleeds ❑ Sinus trouble
- ❑ Sore throats - *frequent*
- ❑ Hoarseness - *prolonged*
- ❑ Hayfever / Allergies
- ❑ Pneumonia / Pleurisy
- ❑ Bronchitis / Chronic cough
- ❑ Shortness of breath:
  - ❑on exertion ❑ lying flat
  - ❑in the past week
  - ❑affects work / lifestyle
- ❑ Leg pain - *when walking*
- ❑ Varicose veins / Phlebitis
- ❑ Cold numb feet
- ❑ Loss of appetite - *recent*
- ❑ Difficulty swallowing
- ❑ Heartburn ❑ Peptic ulcer
- ❑ Aspirin - Arthritis - Pain pills
- ❑ Nausea / Vomiting
- ❑ Gallbladder problem
- ❑ Jaundice / Hepatitis
- ❑ Irritable bowel syndrome
- ❑ Diverticulosis ❑ Chron's ❑ Colitis
- ❑ Inflammatory bowel disease
- ❑ Bloody or tarry stools
- ❑ Test for blood in stools
- ❑ Hemorrhoids ❑ Hernia
- ❑ Urination - Overactive Bladder
  - ❑ Overnight more than twice
  - ❑ More than 8 times / 24 hrs.
  - ❑ Urgency to urinate ❑ with leakage
  - ❑ Painful Urination
  - ❑ Stress incontinence - urine leakage with exercise / movement
  - ❑ Blood in urine ❑ Kidney stones
  - ❑ Urine infections - *frequent*
  - ❑ Bed wetting
- ❑ Weight loss / gain ❑ Appetite
- ❑ Anemia ❑ Bruise easily
- ❑ Blood transfusions
- ❑ Cancer ❑ Easily fatigued
- ❑ Decreased energy / endurance
- ❑ Seizures ❑ Stroke
- ❑ Tremor / hands shaking
- ❑ Arthritis / Rheumatism
- ❑ Bone fracture / joint injury
- ❑ Back pain
- ❑ Foot pain ❑ Gout
- ❑ Rashes ❑ Hives
- ❑ Psoriasis ❑ Eczema
- ❑ Concentration problems
- ❑ Nervousness
- ❑ Agitation ❑ Memory Loss
- ❑ Moodiness ❑ Suicidal thoughts
- ❑ Feelings of worthlessness
- ❑ Phobias ❑ Mental illness
- ❑ Sleep problems - how long _____
  How frequent _____
- ❑ Rheumatic fever ❑ Scarlet fever
- ❑ Tuberculosis
- ❑ Aids / HIV
- ❑ Sexual problems / enjoyment
- ❑ Decreased life enjoyment
- ❑ Decreased work performance
- ❑ Unwanted facial hair
  Hair loss: ❑ progressive ❑ recent

NOTES

NAME: _____ DATE: _____

D.O.B. _____ LMP: _____