OB/GYN History Form

Name _____ **Age** _____ **Date of Birth** _____ **Vitals**

Reason for visit: _____ **BP** _____
Last Menstrual Period: _____ **Height** _____ **Weight** _____ **BMI** _____ **HR** _____
Current Pain: Yes / No **Location of Pain** _____ **Rating of Pain** ____ **(0-10)** **Temp**_____

Occupation: _____ **hCG** _____

Medical History

Anemia Yes / No	Migraines Yes / No	Thyroid Disease Yes / No Type:
High Blood Pressure Yes / No	Blood Transfusions Yes / No	Kidney Disease Yes / No Type:
Asthma Yes / No	Lupus Yes / No	Arrhythmia Yes / No Type:
Heart Disease Yes / No	HIV Yes / No	Cancer Yes / No Type:
Blood Clots Yes / No	Depression Yes / No	Lung Disease Yes / No Type:
Diabetes Yes / No	Anxiety Yes / No	Arthritis Yes / No Type:
Gallstones Yes / No	Liver Disease Yes / No	Other:

Surgical History

Date	Surgery	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Obstetric History (Include miscarriages, abortions, and ectopic pregnancies)

Year	Weeks at delivery	Type of Delivery	Place of Delivery	Sex	Birth weight	Complications

GYN History

How often do you get your period? _____ days	Last pap smear_____ Result _____
How long does your bleeding last? _____ days	Prior abnormal pap smear Yes / No Date:
Heavy cycles Yes / No	Prior Colpo / LEEP / cryotherapy Yes / No Date:
Bleeding between periods Yes / No	Sexually Active Yes / No
Irregular periods Yes / No	On Birth Control Yes / No Type: Tubal ligation / Vasectomy / Other:
Painful periods Yes / No	Pain with intercourse Yes / No
Abnormal vaginal discharge Yes / No	Have you received the HPV vaccine Yes / No
Endometriosis Yes / No	Do you have concerns about your sexual health/activity that you'd like to discuss with your doctor? Yes / No
Pelvic inflammatory disease Yes / No	History of sexually transmitted infection Yes / No Type: Gonorrhea / Chlamydia / Herpes / Trichomonas / Genital warts

Medications

_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____

Social History

Alcohol use Yes / No #drinks____ per day/week/month	Prior / current abuse / assault Yes / No
Tobacco use Yes / No #cigarettes/packs ____ per day	Suicidal Thoughts? Yes / No
Illicit Drug use Yes / No	Employed? Yes / No
Relationship status Married / Single / Divorced Name of Partner: _____	Wear seatbelt? Yes / No

<u>Preventive Medicine</u> Year of prior:

Mammogram _____ Result: _____

Colonoscopy _____ Result: _____

Bone Density Scan _____ Result: _____

<u>Family History</u>

Breast Cancer Yes / No Relationship: Age at diagnosis:	Diabetes Yes / No
Ovarian Cancer Yes / No	High Blood Pressure Yes / No
Colon Cancer Yes / No	Heart Disease Yes / No
Cervical Cancer Yes / No	Stroke Yes / No
Uterine Cancer Yes / No	High Cholesterol Yes / No

<u>Other Symptoms</u>

Have you had recent:

__ Weight Loss
__ Weight gain
__ Hair growth
__ Hair loss
__ Hot flushes
__ Breast discharge
__ Other: _____

<u>Only fill out the remaining portion if you are pregnant or planning to become pregnant</u> Have you or the baby's father or anyone in your families had any of the following:

__ Down Syndrome
__ Other Chromosomal abnormality
__ Neural tube defect (spina bifida, anencephaly)
__ Hemophilia or other bleeding disorder
__ Muscular Dystrophy
__ Tay-Sach's disease
__ Sickle cell trait or disease
__ Thalassemia
__ Cystic Fibrosis

Have you been exposed to or had:

__ Hepatitis B
__ Tuberculosis
__ Chicken Pox