OB/GYN History Form

Name: _____ DOB: _____ Date: _____
Age: _____ Height: _____ Weight: _____

Last Menstrual Period: _____ Last Pap Smear: _____

History of Abnormal Pap? Yes / No When? _____ Treatment? Colposcopy / Leep / Cryotherapy

Menses/Birth Control

Age at onset of periods: _____ Are our period Regular: _____ Irregular: _____

How often do you get your period? ___ Less than 20 days apart ___ 21-30 days ___ 30-40 days ___ More than 40 days apart How many days does your period last? ___Less than 2 ___ 2-5 days ___ 5-7 days ___ 7-10 days ___ More than 10 days How many pads/tampons do you use on heavy days? _____ Do you miss work/school monthly? Yes / No Do you spot between periods? Yes / No Do you have pain with your periods? Yes / No Have you had the Gardasil Vaccine? Yes / No Which form of birth control, if any, do you use? Vasectomy ____ Tubal Ligation ____ Other _____ Are you currently sexually active? Yes / No Other? _____	Do you bleed after intercourse? Yes / No Do you have pain with intercourse? Yes / No Have you had discharge for >6 months? Yes / No If so, how long? _____ Is there odor? Yes / No Itching? Yes / No Do you we yourself with any of the following: Coughing / Sneezing / Laughing / Running / Lifting Do you leak with urge or can't make it to the bathroom? Yes / No How often do you use the bathroom in a 24 hour period? _____ Do you have chronic constipation? Yes / No Any recent changes in bowel habits? Yes / No If yes, what change? _____ Do you have a vaginal bulge? Yes / No Any Nipple discharge? Yes / No

Medical History – Patient

Have you had or do you presently have any of the following?

Anemia: Yes / No	DEXA scan: Yes / No When?	High Blood Pressure: Yes / No
Anxiety: Yes / No	Depression: Yes / No	Kidney Disease: Yes / No
Arthritis: Yes / No	Diabetes: Yes / No	Lung: Disease: Yes / No Type:
Asthma: Yes / No	Fibromyalgia: Yes / No	Lupus: Yes / No
Bleeding Disorder: Y/N Type:	Genital Wart: Yes / No	Mammogram: Yes / No When?
Blood Clots: Y/N Type:	Gonorrhea: Yes / No	Migraines: Yes / No
Cancer: Y/N Type:	Heart Disease: Yes / No	Mood Disorder: Yes / No
Chicken Pox: Yes / No	Arrhythmia: Yes / No	Sickle Cell: Yes / No
Chlamydia: Yes / No When?	Herpes: Yes / No	Sexually active (ever): Yes / No
Colonoscopy: Yes / No When?	HIV: Yes / No	Thyroid Disease: Y/N Type:

Other Medical Problems: _____

Your Preferred Pharmacy: _____

Family History

Diabetes Yes / No Heart Disease Yes / No Hypertension Yes / No

Cancer: Breast Uterine Ovarian Colon None

Other: _____

Surgical History – Patient

Date	Procedure	Hospital

Medications

Name	Dosage	Frequency

Any Allergies to Medications: _____

Obstetric History

Have you ever been pregnant? Yes / No **(*if no, proceed to Social History*)**
If yes, how many times have you been pregnant? _____
Have you ever had an abortion or miscarriage? Yes / No If yes, how many? _____
How many living children do you have? _____

Birth Date	Weeks at Delivery	Boy / Girl	Weight	Vaginal/C-Section	Complications

Social History

Do you smoke? Yes / No If yes, How much do you smoke? _____
Do you drink alcohol? Yes / No If yes, how much do you drink? _____
Do you use illicit or "street" drugs? Yes / No If yes, what and how much do you use? _____
Are there other problems you need to discuss with your physician? _____
Are you Married? _____ Divorced? _____ Single? _____
Husband/Significant Other's name: _____
Your Employment: _____