

OB / GYN HISTORY FORM

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

Past Obstetrical History - To include 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Last Mammogram	Your partner is <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both
Age of 1st period	Contraception
Last menstrual period	Age at Menopause
Duration of flow	Bone Density <input type="checkbox"/> Yes - when _____, <input type="checkbox"/> No
Cramps? Mild / Mod / Severe / None	Osteopenia <input type="checkbox"/> Yes <input type="checkbox"/> No
Time between periods	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Allergies - List Reaction

Medications & Dosage - Include Vitamins / Herbs

CONTINUE ON BACK SIDE

Past Medical History

Diabetes Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots Leg/Lung Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Tract Infections Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic/Epilepsy Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Dysfunction Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Liver Disease Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	In Utero DES Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia Complications Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Comments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunization History Have you been vaccinated against Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Have you been vaccinated against Influenza? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Have you been vaccinated against Pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Have you been vaccinated against Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Have you had chicken pox? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, have you been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had Rubella (German Measles)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, have you been vaccinated? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a PPD skin test? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> positive or <input type="checkbox"/> negative.					
Surgeries (Reason & Year)				Hospitalizations (Reason & Year)	
1	5			1	
2	6			2	
3	7			3	
4	8			4	

Family History

Breast Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia Complications Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ovarian Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Defects/Hereditary Disorders Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uterine Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Cancer Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gynecological Problems Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Disorder Who:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Social History

Occupation	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Social Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:	Type: How often:
Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No For how long:	Pack/day: Quit date:	Abuse/Domestic Violence <input type="checkbox"/> Yes <input type="checkbox"/> No Past or Present Relationship	
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:	Type: How often:	Advance Directives <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please bring copy for your chart. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Review of Systems (Check all that apply and explain if necessary)

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