

OB/GYN HISTORY

Name _____ Date of Birth _____ Date _____

Reason for Visit / Chief Complaint _____

Primary Care Physician _____

Menstrual History

Age when started first menstrual cycle _____ First day of last menstrual period _____
Number of days from the first day of one cycle to the first day of next cycle _____
Duration (how many days of flow?) _____ Amount (light, moderate, heavy) _____
Cramping (mild, moderate, severe?) _____ Helped with medication _____
What type of contraceptive (birth control device) do you use? _____

When was your last Pap smear? _____ Where? _____ Was it normal? _____
When was your last Mammogram? _____ Where? _____
When was your last DEXA (bone density scan)? _____ Where? _____

Menopausal History

Age of onset of menopause _____
Are you experiencing menopausal symptoms? _____
Are you currently on hormone replacement therapy? _____

Obstetrical History

_____ Number of living children	_____ Number of miscarriages/abortions
_____ Number of premature deliveries	_____ Number of vaginal deliveries
_____ Number of full term births	_____ Number of Cesarean section

Surgical History

List all surgeries you have every had (include C-sections, tonsillectomy, gallbladder, oral, etc.)

Date of surgery:	Type of surgery:
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a colonoscopy? _____ If yes, When? _____ Where? _____

Family History

Father – (circle one) Living Deceased
List any known illnesses, medical conditions, cause of death. _____

Mother – (circle one) Living Deceased
List any known illnesses, medical conditions, cause of death. _____

Please complete reverse side of form. OVER →

