OB/GYN HISTORY

Name _____Date of Birth _____ Date of Appt _____

Reason for Visit: □ Annual Exam □ Birth Control □ Problem (Please describe problem)

_____

_____

Do you have a primary care physician? □ Yes □ No **Physician's name_____**

Pharmacy _____ Location _____

Medical Conditions

List any medical conditions that you have (diabetes, asthma, hypertension, high cholesterol, cancer history, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

History in you or your sexual partner(s) of: Syphilis, sores, gonorrhea, herpes, blisters, trichomonas, warts, pelvis or tubal inflammation (PID), or other sexually transmitted diseases?
□ Yes □ No **If yes, indicate which STD's below**:

_____

Are you allergic to any medications or latex? □ Yes □ No If yes, please list below.

Drug	**Your Reaction(s)**	**Drug**	**Your Reaction(s)**
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any foods? □ Yes □ No If yes, please list below

_____ _____ _____

Family History

Mother –□ Living □ Deceased Any medical problems? □ Yes □ No If yes, please list:

_____

Father – □ Living □ Deceased Any medical problems? □ Yes □ No If yes, please list:

_____

Do you have any siblings with any medical problem? □ Yes □ No If yes, please list.

□ **Brother** □ **Sister** □ Living □ Deceased _____

□ **Brother** □ **Sister** □ Living □ Deceased _____

□ **Brother** □ **Sister** □ Living □ Deceased _____

□ **Brother** □ **Sister** □ Living □ Deceased _____

Is there any family history of cancer? □ Yes □ No Please list which relative and type of cancer.

Relative		**Type of Cancer**
_____	□ Mother's side □ Father's side □ Living □ Deceased	_____
_____	□ Mother's side □ Father's side □ Living □ Deceased	_____
_____	□ Mother's side □ Father's side □ Living □ Deceased	_____
_____	□ Mother's side □ Father's side □ Living □ Deceased	_____

Please complete reverse side of form. OVER→

Name ___________________________Date of Birth __________ Date of Appt ___________

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Patient Occupation ______________ Spouse's Name: _____________ Spouses Occupation ___________
Do you exercise? ☐ Yes ☐ No Type_____________________ How many days per week? ________
Do you use illicit/street drugs? ☐Yes ☐ No Type ________________________ How often? _______
Do you drink alcohol? ☐Yes ☐ No How much? _________________ How often? _______________
☐ Current Tobacco User ☐ Never Tobacco User ☐ Former Tobacco User: Age Quit ______
☐ Cigarettes ☐ Cigars ☐ Snuff/Dip ☐ Chewing Tobacco ☐ Other _______________________
How many packs per day? ___________________________ How many years? ______________________
How many caffeinated drinks do you have in a day? _________________ ☐ Coffee ☐ Tea ☐ Soda

Current Medications: Do you take medications? ☐ Yes ☐ No (Include birth control, creams, aspirin, vitamins, hormones, supplements, etc)

Name of Medication & Strength	How often you take it
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____
______________________________	☐ Daily ☐ Weekly ☐ Monthly ☐ As Needed ☐ Other _____

Obstetrical History

Number of: Pregnancies_____ Full term births ____ Premature births _____ Live births _____
Number of: Cesarean sections _____ Miscarriages_____ Abortions _____

Menstrual History

Do you still have menstrual cycles? ☐ Yes ☐ No If no, cycles stopped because of ____________
Age when started first menstrual cycle ________ Flow: ☐ Light ☐ Moderate ☐ Heavy
Number of days from the first day of one cycle to the first day of next cycle ________________
How many days of flow? _____________ Cramping? ☐ None ☐ Mild ☐ Moderate ☐ Severe
First day of last menstrual cycle? ______________ Type of birth control used? ________________

Menopausal History

Age of onset of menopause ________ Are you having menopausal symptoms? ☐Yes ☐ No
Are you currently on hormone replacement therapy? ☐Yes ☐ No

Surgical History (Include C-sections, tonsillectomy, gallbladder, oral, etc.)

Date of surgery:	Type of surgery:
________________	____
________________	____
________________	____
________________	____

Diagnostic / Health Maintenance

When was your last Pap smear? _________ Results: ☐ Normal ☐ Abnormal. Where?_________
When was your last mammogram? ______________ Where? ____________________________
When was your last bone density scan (DEXA)________ Result: ☐ Normal ☐ Osteopenia ☐ Osteoporosis
Have you ever had a colonoscopy? ☐Yes ☐ No If yes, what year? ________ Where? __________

***Please Mail, Fax or Bring Completed Form to Our Office Prior to Your Appointment.**