## Obstetrics and Gynecology History Form

**Name:** _____ **Age:**_____ **Date:** _____

**Reason for Visit**:_____

**Allergies:** _____

**Primary Care Physician:**_____**Referring Physician:**_____

Race: _____Asian _____Black or African American ____Native American ____White Other_____

Language: _____English _____Spanish Other_____

Past Medical History: Please list all prior medical diagnosis

_____ _____

_____ _____

_____ _____

Past Surgical History: Please list all surgeries and dates

_____ _____

_____ _____

_____ _____

Please List Significant Medical Conditions in your Family, and who has/had them (breast cancer – mother, heart disease – grandfather, etc):

_____ _____

_____ _____

_____ _____

| **Medication Name** | **Dosage** | **Frequency** |
|---|---|---|
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Marital Status: Married Divorced/Separated Single Widowed

Do you smoke? No Yes How many packs per day? _____

Do you drink alcohol? No Yes How many drinks per week?_____

Do you currently or have you ever used illegal drugs? No Yes Please List:_____

Do you exercise? No Yes How often?_____

| First Day of Last Menstrual Period | # of Days Between Menstrual Periods | # of Days Menstrual Period Lasts | Are your periods: Regular Irregular<br>Flow: Light Moderate Heavy - # of pads/tampons per day_____<br>Cramps: Mild Moderate Severe |
|---|---|---|---|
| | | | |

Age at which you had your first menstrual period: _____ Age at which you started Menopause _____

Are you having any menstrual problems? No Yes, Describe _____

If you are menopausal, are you having any vaginal bleeding? No Yes, Describe _____

When was your last Pap Test?: _____ Was it normal: Yes No

Have you ever had an abnormal Pap test?: No Yes, When _____

Date of last mammogram: _____ Date of last DEXA (bone density scan): _____

Date of last colonoscopy: _____ Date of last Tdap/Tetanus vaccine: _____

Have you received the HPV vaccine? No Yes

Current Contraception: _____ Do you use condoms? Yes No

What type(s) of birth control have you used in the past? IUD Oral Contraceptives Depo Provera Other_____

Are you currently sexually active? Yes No Are your partners: Male Female Both

Do you want to be tested for sexually transmitted diseases (STDs)? Yes No

Number of sexual partners over lifetime: _____ Number of times you have sex per month: _____

Please Circle: Have you ever had any of the following STDs:

None Chlamydia Gonorrhea Venereal Warts Genital Herpes HPV Other_____

| Pregnancy Dates | Vaginal Delivery or C-Section | Complications | Pregnancy Dates | Vaginal Delivery or C-Section | Complications |
|---|---|---|---|---|---|
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**Number of:**

Miscarriages:_____ Terminations: _____ Living Children:_____

## Review of Systems:

Please ☑ any of the following that you are currently experiencing problems with:

- ☐ Unexplained weight change
- ☐ Fever
- ☐ Dizzy spells/fainting
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Coughing
- ☐ Trouble breathing
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Heartburn/Indigestion
- ☐ Trouble with balance
- ☐ Severe joint/muscle pain
- ☐ Skin lesions
- ☐ Headaches
- ☐ Trouble sleeping
- ☐ Hot flashes/Night Sweats
- ☐ Difficulty concentrating
- ☐ Hair loss or thinning
- ☐ Excess body/facial hair
- ☐ Unusual fatigue
- ☐ Heat or cold intolerance
- ☐ Frequent bruising
- ☐ Domestic Violence
- ☐ Victim of sexual abuse
- ☐ Pain During Urination
- ☐ Increase in urinary frequency
- ☐ Blood In Urine
- ☐ Urinary Incontinence
- ☐ Pelvic Pain
- ☐ Vaginal discharge or odor
- ☐ Vulvar itching or rash
- ☐ Vaginal Dryness
- ☐ Premenstrual symptoms
- ☐ Breast Pain
- ☐ Pain or bleeding with sex
- ☐ Decreased sexual desire