FOR OFFICE USE

OBSTETRICS & GYNECOLOGY MEDICAL HISTORY FORM

Patient Name: ______________________

What is the reason for today's visit? ______________________

List MEDICATIONS you are **ALLERGIC** to and your **REACTIONS** ☐ **NO KNOWN DRUG ALLERGIES**

Allergic Medication Name: ______________________

Type of Reaction (rash, hives, throat swelling, shortness of breath, etc.) ______________________

☐ LATEX ALLERGY

What **MEDICATIONS** are you currently taking? ☐ **NOT TAKING ANY MEDICATIONS**

Medication Name	Dosage (mg, gram, IU, etc.) Frequency (once or twice a day, etc.)	Medication Name	Dosage (mg, gram, IU, ect.) Frequency (once or twice a day, etc.)

FAMILY HISTORY (Check the following Cancers or List Medical Conditions found in a Family Member)

	Yes	None	Age	Relation (Mother, Father, Sister, Brother, Children, Grandparents, etc.)
Breast Cancer	☐	☐	___	
Ovarian Cancer	☐	☐	___	
Colon Cancer	☐	☐	___	

Other Medical Problems in the Family: ______________________

IMMUNIZATIONS

Did you get your flu shot? ☐ Yes ☐ No If Yes, Date: __________ If No, Reason: __________

MEDICAL HISTORY ☐ **NO MEDICAL PROBLEMS EVER DIAGNOSED**

☐ BREAST CANCER - MO/YR ______
☐ OVARIAN CANCER - MO/YR ______
☐ COLON CANCER - MO/YR ______
☐ UTERUS CANCER - MO/YR ______
☐ CERVICAL CANCER - MO/YR ______
☐ OTHER CANCER: ______
☐ CHEMOTHERAPY
☐ RADIATION THERAPY
☐ BLOOD CLOTS
*WHERE? ______
☐ STROKE
☐ ANEMIA

☐ DIABETES
☐ HIGH BLOOD PRESSURE
☐ MITRAL VALVE PROLAPSE
☐ HEART DISEASE
☐ RREGULAR HEART RATE
☐ HIGH CHOLESTEROL
☐ ASTHMA
☐ HYPOTHYROIDISM (LOW)
☐ HYPERTHYROIDISM (HIGH)
☐ MIGRAINES
☐ SEIZURE DISORDER
☐ GLAUCOMA

☐ LOSS OF URINE CONTROL
☐ BLOOD IN URINE
☐ FREQUENT BLADDER INFECTION
☐ VAGINAL DRYNESS / ITCHING
☐ FREQUENT VAGINAL INFECTION
☐ PAINFUL INTERCOURSE
☐ PELVIC INFLAMMATORY DISEASE
☐ ABNORMAL HEAVY VAGINAL BLEEDING
☐ UTERINE FIBROIDS
☐ FIBROCYSTIC BREASTS
☐ NIPPLE DISCHARGE
☐ CERVICAL DYSPLASIA

☐ OSTEOPOROSIS
☐ OSTEOPENIA
☐ ARTHRITIS
☐ DEPRESSION
☐ ANXIETY
☐ SEXUAL ABUSE
* ARE YOU SAFE NOW?
☐ DOMESTIC ABUSE
* ARE YOU SAFE NOW?
☐ PSYCHIATRIC PROBLEMS
☐ OTHERS: ______

BIRTH CONTROL & MENSTRUAL HISTORY

What form of BIRTH CONTROL are you currently using? ☐ NONE

☐ Condoms
☐ I had a Tubal Ligation (Tubes Tied)
☐ I had a HYSTERECTOMY (Uterus Removed)
☐ My partner had a VASECTOMY
☐ Rhythm Method / Natural Family Planning

☐ Withdrawal
☐ Diaphragm
☐ Spermacide
☐ Nexplanon
☐ IUD Name: ______

☐ Depo-Provera Shots / Date Last Shot Given: ______
☐ Contraceptive Film
☐ Birth Control Pills / Brand: ______
☐ Nuvaring
☐ Other: ______

Have you gone through Menopause? ☐ Yes ☐ No (What age? ______) Hormone Medication & Dosage: ______

When was the first day of your Last Menstrual Period? ____/____/____ ☐ **I DON'T GET A PERIOD**

Do you have Normal Periods? ☐ Yes ☐ No

At what age did you have your First Menstrual Period? ______ years old.

THIS FORM IS CONFIDENTIAL AND A PART OF YOUR MEDICAL RECORDS

Patient Name: ______________________________ DOB: ______________ Date: ____/____/____

Infection History Check the following Infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past.

- ☐ NONE EVER
- ☐ Chlamydia
- ☐ Gonorrhea (gc, clap)
- ☐ Hepatitis (☐ B or ☐ C)
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Bacterial Vaginosis (Gardnerella)
- ☐ Human Papilloma Virus (HPV)
- ☐ Herpes (☐ Genital or ☐ Oral) If yes, are you taking medication? ☐ Yes ☐ No
  * If yes, Name & Dosage ______________________________
- ☐ Others: ______________________

How many Sexual Partners in your lifetime? ☐ 0 ☐ 1- 4 ☐ 5 or greater
(Optional Question)

Are you Currently Sexually Active? ☐ Yes ☐ No

When was your Last Pap Smear? (Approximate Date) _____/_____/_____ Was your Last Pap Smear Normal? ☐ Yes ☐ No ☐ I don't know
Have you ever had an Abnormal Pap Smear? ☐ Yes ☐ No * If Yes, please specify what Procedure was done? ____________________

When was your Last Mammogram? (Approximate Date) _____/_____/_____ ☐ NEVER DONE
Was your Last Mammo Normal? ☐ Yes ☐ No Have you ever had an Abnormal Mammo? ☐ Yes ☐ No

OBSTETRICAL HISTORY ☐ **NEVER PREGNANT**

How many times have you been Pregnant? ______
How many children have you delivered? ______
How may were born full term (37 weeks or greater)? ______
How many were premature (less than 37 weeks)? ______
How may miscarriages did you have? ______
How may abortions did you have? ______
How many children are currently living? ______
How many sets of twins? ______

SOCIAL HISTORY

Do you smoke cigarettes? ☐ No ☐ Yes ____ ☐ Packs ☐ Cigarettes / per ☐ Day ☐ Week Quit (date) _____/_____/______
Do you drink alcohol? ☐ No ☐ Yes ____ drinks per ☐ Day ☐ Week ☐ Social Type: ☐ Beer ☐ Wine ☐ Liquor Quit ____/____/_____

Do you get regular exercise? ☐ Yes ☐ No

Where do you work? ____________________ Occupation: ______________________ ☐ Homemaker ☐ Student ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Living with partner ☐ Widowed ☐ Divorced / Separated

Which illicit drugs have you used? ☐ None
(Optional Question)

- ☐ Marijuana
- ☐ Cocaine, Crack
- ☐ Ecstacy, MDMA
- ☐ Methamphetamine
- ☐ PCP, LSD
- ☐ Morphine, Heroin
- ☐ Others: ________________
- ☐ Quit using all illicit drugs

SURGICAL HISTORY (Check the following Surgeries or Procedures) ☐ **NEVER HAD ANY SURGERIES**

- ☐ TUBAL LIGATION
- ☐ CESAREAN SECTION
- ☐ HYSTERECTOMY (YEAR: _________)
  REASON: ____________________
  ☐ ABDOMINAL ☐ VAGINAL
- ☐ MYOMECTOMY, FIBROID REMOVAL
- ☐ OVARIES REMOVED
  ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ OVARIAN CYST REMOVAL
  ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ ECTOPIC PREGNANCY SURGERY
  ☐ ABDOMINAL ☐ LAPAROSCOPIC
  ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ BLADDER SURGERY

CERVIX SURGERY:
- ☐ CRYOTHERAPY (FREEZING)
- ☐ LEEP (HEATED WIRE)
- ☐ CONIZATION (COLD KNIFE CUTTING)

- ☐ LAPAROSCOPY
- ☐ D&C (DILATION & CURETTAGE)
- ☐ HYSTEROSCOPY
- ☐ ENDOMETRIAL ABLATION
- ☐ VAGINAL SURGERY
- ☐ BREAST LUMP REMOVAL
  ☐ RIGHT ☐ LEFT ☐ BOTH
  ☐ BENIGN ☐ MALIGNANT
- ☐ MASTECTOMY
  ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ BREAST IMPLANTS ☐ REDUCTION
- ☐ TONSILLECTOMY
- ☐ THYROID SURGERY
- ☐ HEART SURGERY
- ☐ STOMACH SURGERY
- ☐ LUNG SURGERY
- ☐ LIVER SURGERY

- ☐ GALLBLADDER SURGERY
- ☐ APPENDECTOMY (APPENDIX)
- ☐ SPLENECTOMY (SPLEEN)
- ☐ UMBILICAL HERNIA REPAIR
- ☐ ABDOMINOPLASTY (TUMMY TUCK)
- ☐ COLON SURGERY
- ☐ COLONOSCOPY DATE: ____/____/_____
- ☐ SIGMOIDOSCOPY DATE: ___/___/_____
- ☐ HEMORRHOID SURGERY
- ☐ LOWER GI – BARIUM ENEMA
- ☐ BONE FRACTURE SURGERY
  WHICH BONES? ________________
- ☐ SPINAL SURGERY
  LEVEL: ____________________
- ☐ DEXA BONE DENSITY SCAN
  DATE: ____/____/_____
- ☐ OTHERS: ____________________
  ____

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Patient Signature ____________________________ Provider Signature ____________________