



**associated**  
Obstetrics & Gynecology  
*caring for women*

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## OB/GYN History

Office Use Only

Patient # \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Note: This record is confidential. Information will not be released to anyone without your authorization.

### Menses/Birth Control

Age at Onset \_\_\_\_\_  Regular  Irregular

How often do you get your period?

- Less than 20 Days Apart  21-30 Days Apart  
 30-40 Days Apart  More Than 40 Days Apart

How many days does your period last?

- Less Than 2 Days  2-5 Days  5-7 Days  
 7-10 Days  More Than 10 Days

How many pads/tampons do you use on heavy days? \_\_\_\_\_

Do you pass clots?  Yes  No How large? \_\_\_\_\_

Do you miss school/work monthly?  Yes  No

Do you have frequent headaches?  Yes  No

Which form of birth control (if any) do you use? \_\_\_\_\_

Do you spot/bleed between periods?  Yes  No

Do you have bleeding after intercourse?  Yes  No

Do you have pain with your periods?  Yes  No

Do you have pain with intercourse?  Yes  No

Do you have a chronic discharge?  Yes  No

Is there odor?  Yes  No Itching?  Yes  No

Is there blood in your urine?  Yes  No

Do you get up multiple times at night to urinate?  Yes  No

Do you wet yourself with any of the following:  
coughing, sneezing, laughing, running, lifting?  Yes  No

Do you have chronic constipation or diarrhea?  Yes  No

Any recent change in bowel habits?  Yes  No

### Medical History - Patient

Have you had or do you presently have any of the following?

Heart Disease  Yes  No

Lupus  Yes  No

Arthritis  Yes  No

High Blood Pressure  Yes  No

Diabetes  Yes  No

Kidney Disease  Yes  No

Phlebitis or Blood Clots  Yes  No

Migraines  Yes  No

Thyroid Disease  Yes  No

Cancer  Yes  No

Bleeding Tendencies  Yes  No

Lung Disease  Yes  No

Chicken Pox  Yes  No

HIV  Yes  No

Herpes  Yes  No

Genital Warts  Yes  No

Chlamydia or Gonorrhea  Yes  No

Sickle Cell Disease or Trait  Yes  No

Anemia  Yes  No

Please describe any "yes" answers. \_\_\_\_\_

### Medical History - Family

Family Member	Age	State of Health	Specific Disease	If Deceased Age	If Deceased Cause
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



Name \_\_\_\_\_

Patient # \_\_\_\_\_ Date \_\_\_\_\_

**Social History**

Do you ever feel unsafe at home?  Yes  No

Has anyone at home hit you or tried to injure you?  Yes  No

Have you ever felt afraid of your partner?  Yes  No

Has anyone ever threatened you or tried to control you?  Yes  No

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_

Are there other problems you need to discuss with your physician? \_\_\_\_\_

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Completed by (If other than patient) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_