Aspire for Women Obstetrics and Gynecology, a Member of OBGYN Affiliates
Gynecologic History

Name: _____ **DOB:** _____ **Age:** _____ **Today's Date:** _____

Allergies:_____

Medications
Name / Dose _____ _____ _____ _____

Gynecologic History

Age at first period: _____ Date of last period: _____ Exact / Approx / Unknown

Do your periods come regularly? Yes / No Every (how many) _____ days Lasting for _____ days

Flow: Heavy / Mod / Light Cramps: Mild / Mod / Severe Bleeding between periods? Yes / No

Sexual History

Are you sexually active? Yes / No Men / Women / Both Lifetime partner count: _____

# of partners in last 6 mo: _____ Pain with intercourse? Yes / No Bleeding after intercourse? Yes / No

History of an STD? Yes / No Chlamydia / Gonorrhea / Herpes Date of diagnosis:_____

Treated? Yes / No Trichomonas / Syphilis

Pap History

Date of last pap smear: _____ History of abnormal pap? Yes / No Colposcopy (biopsy) / LEEP / Cone

Did you get the HPV vaccine? Yes / No Date: _____ # of shots in you received: 1 / 2 / 3

Contraception (Circle one or more) Abstinence Calendar/Rhythm Condoms Hysterectomy IUD Nexplanon Pill Ring Tubal ligation Vasectomy Withdrawal Nothing

Condom Usage? Always / Usually / No

Health Maintenance

Date of last: Mammogram: _____ Bone density scan: _____ Colonoscopy: _____

Menopause Not applicable ____

Age at menopause: _____ Bleeding after menopause? Yes / No Hormone replacement therapy? Yes / No

OB History Total pregnancies _____ Full term _____ Preterm _____ Abortions _____

Ectopic _____ Miscarriage _____ Multiples birth _____ Living Children _____

	Child's Name/DOB:	Gestational age:	Weight of baby:	Vag/C section:	Complications:
Preg #1					
Preg #2					
Preg #3					
Preg #4					
Preg #5					
Preg #6					

Social History

Tobacco: Current / Former / Never Packs per day: _____ How many years? _____

E-cig/Vape: Current / Former / Never Cartridge strength: _____ Cartridge freq: _____

Marijuana use? Yes / No Smoke / Vape / Edibles Freq: _____

Illicit drug use? Yes / No If yes, what kind? _____

Currently employed? Yes / No Occupation: _____ Education level: _____

Single / Married / Divorced / Widowed Live with others? Yes / No # of children in your home: _____

Alcohol intake? None / Occ / Mod / Heavy # of drinks / week? _____ Bev of choice: _____

Caffeine intake? None / Occ / Mod / Heavy # of drinks / day? _____ Bev of choice: _____

Self-breast exam? Yes / No If yes, how often?_____ Seat belts used routinely? Yes / No

Diet: Regular / Vegetarian / Vegan / Gluten free / Diabetic / Keto / Cardiac / Paleo

Safety

Do you feel safe at home? Yes / No Has anyone close to you ever threatened to hurt you? Yes / No

Are you afraid of your partner? Yes / No Has anyone ever forced you to have sex? Yes / No

List all **Surgeries** you've had:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Medical History

	Yes	No		Yes	No		Yes	No
Abuse/Domestic Violence			Breast problem			High cholesterol		
Acid Reflux (GERD)			Cancer			High blood pressure		
Acne			Depression			Infertility		
Anemia			Diabetes			Kidney/Bladder problem		
Anesthesia comp.			Skin disorder			Liver problems		
Anxiety			Eating disorder			Migraines with Aura		
Arthritis			Endometriosis			Osteoporosis		
Auto immune disease			Fibroids			Psychiatric illness		
Asthma			GI problems			Seizures		
Birth defects			Headaches			Stroke		
Blood clots			Heart problem			Thyroid problems		
Blood transfusion			Hematologic disorder			Uterine problems		

Family History

	Cancer	Heart attack	Stroke	Diabetes	High blood pressure	Thyroid disease	Endometriosis	Substance abuse	Blood Clot
Yes (If yes, details)									
No									