A Bella Baby OBGYN

Gynecology History and Intake

Patient Name: _____ **Date of Birth:** _____

Why have you come to see us today: _____

_____

_____

_____

Preferred Local Pharmacy: _____

Preferred Notification Method: ☐ **Mail** ☐ **Phone** ☐ **Email** ☐ **Text**

Gynecologic History

First date of last menstrual period: _____

Age periods began: _____

Length of period (number of days of bleeding) _____

Number of days between periods: _____

Any recent changes in periods? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently sexually active? ☐ Yes ☐ No

Number of sexual partners (lifetime); _____

Present method of Birth control: _____ ☐ None

Have you ever used and intrauterine device (IUD) or birth control pills? ☐ Yes ☐ No

If yes for how long? _____

When was your last pap smear? _____ What was the result? _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

If yes: How was it treated? _____

Do you do regular breast examinations? ☐ Yes ☐ No

OB History

How many times have you been pregnant? _____ How many spontaneous miscarriages? _____

How many pre term deliveries? _____ How many ectopic pregnancies? _____

How many full term deliveries? _____ How many terminations? _____

How many stillbirths? _____ How many live births? _____

Date of Birth	Sex	Weight	Length of labor	Vaginal or Cesarean	Complications with pregnancy or delivery

OB details: _____

_____

_____

Medications:

List any medications, vitamins, minerals, and herbs that you are currently taking ☐ No Current Meds

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Allergy History:

List known allergies (including medication allergies) or check one of the boxes below

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

_____
_____
_____
_____
_____

Medical History:

Please indicate any maternal or family history that applies to you with a check mark placed on the lines below.

	You	Family		You	Family
Abuse	☐	☐	HIV	☐	☐
Alcohol Use	☐	☐	HPV	☐	☐
Anemia	☐	☐	Hypertension	☐	☐
Autism	☐	☐	Infertility	☐	☐
Autoimmune Disorder	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Liver Disease	☐	☐
Bleeding/Clotting Disorder	☐	☐	Lung Disease	☐	☐
Blood Disorder	☐	☐	Multiple Gestation	☐	☐
Caffeine Use	☐	☐	Neurologic Disorder	☐	☐
Cancer	☐	☐	Pelvic Surgery	☐	☐
Chromosomal Anomaly	☐	☐	Psychiatric Disorder	☐	☐
Congenital Anomaly	☐	☐	Rh incompatibility	☐	☐
Depression	☐	☐	Seizure disorder	☐	☐
DES Exposure	☐	☐	Sexually Transmitted Disease	☐	☐
Diabetes Mellitus	☐	☐	Thyroid disease	☐	☐
Drug use	☐	☐	Tobacco use	☐	☐
Endocrine Disorder	☐	☐	Trauma	☐	☐
Gastrointestinal disorder	☐	☐	UTI/Recurrent UTI	☐	☐
General Anesthesia/Reaction	☐	☐	Uterine Anomaly	☐	☐
Heart Disease	☐	☐	Vascular disease	☐	☐
Hepatitis	☐	☐	Violence	☐	☐
Herpes	☐	☐			

Past Surgical History: List significant surgeries or injuries ☐ None

_____
_____
_____
_____
_____

Social History:

Please describe your current tobacco use?
☐Never Smoker ☐Former Smoker ☐Current every day smoker ☐Current some day smoker
☐Current status unknown ☐Unknown if ever smoked

Are you exposed to "second-hand" smoke**?** ☐Yes ☐No
If yes, please indicate by marking the appropriate boxes: ☐Minimal ☐Frequent ☐Daily
☐Family members smoke indoors ☐Family members smoke outdoors only

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day:
_____

Have you ever used any illicit drugs? ☐Yes ☐No
If yes, please indicate what type of drug and how often:
_____

Do you drink beverages with alcohol? ☐Yes ☐No
If yes, please indicate what type of beverage and how many servings per day:
_____

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

Review of Systems:

- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Rash
- ❑ Blurred Vision
- ❑ Headache
- ❑ Bleeding Gums
- ❑ Difficulty Breathing
- ❑ Breast Mass
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ Elevated Blood Pressure
- ❑ Shortness of Breath
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Nausea
- ❑ Vomiting
- ❑ Contractions, Regular
- ❑ Frequency
- ❑ Decreased Fetal Movement
- ❑ Painful Urination
- ❑ Pelvic Pain
- ❑ Urinary Complaints
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge
- ❑ Vaginal Fluid
- ❑ Back Pain
- ❑ Leg Cramps
- ❑ Dizziness
- ❑ Depression

Submitting Your Questionnaire to A Bella Baby OBGYN

Once you have completed the form fields above there are two ways to send your completed information:

1) **Email.** Save this PDF to your computer with a unique name. i.e. “Jane Doe’s Questionnaire.pdf”. Then email this completed form as an email attachment to **abellababyobgyn@outlook.com**

2) Fax: 630-810-1077