Newport Beach OB/GYN Medical Group, Inc.

Health History Form

Patient Name: _____ Date: _____ DOB: _____

Reason for visit: _____ Primary Care Physician: _____

Referred by: _____ Occupation: _____

Pharmacy: _____

Have you had any of the following (circle all that apply):

Abnormal Mammogram	Fibroids – uterine	Liver Disease
Abnormal Pap Smear	Frequent Bladder Infections	Lupus
Anemia	Genetic Disorder	Osteopenia
Arthritis	Genital Herpes	Osteoporosis
Asthma/Emphysema	GERD	Painful Periods
Blood Transfusion	Headache/Migraine	Problems with Anesthesia
Cancer (type): _____	Heart Disease	STDs
Clotting Disorder	High Cholesterol	Stroke
Depression	High Blood Pressure	Thyroid Disease
Diabetes Type I or II	Irregular Vaginal Bleeding	Other: _____
Endometriosis	Irritable Bowel/Colon	
Epilepsy	Kidney Disease	

Your Most Recent:	**Date:**	**Results:**
Pap smear:	_____	_____
HPV test:	_____	_____
Mammogram:	_____	_____
Colonoscopy:	_____	_____
DEXA:	_____	_____

List all Medications:	**Dose:**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Allergies:	**Reaction:**
_____	_____
_____	_____

List all Surgeries and Procedures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Family History:

Condition:	Family Member:	Age Dx	Condition:	Family Member	Age Dx
Breast Cancer	_____	_____	DVT/PE/Clots	_____	_____
Colon Cancer	_____	_____	Heart Disease	_____	_____
Ovarian Cancer	_____	_____	Diabetes	_____	_____
Uterine Cancer	_____	_____	Hypertension	_____	_____
Osteoporosis	_____	_____	Thyroid Disease	_____	_____

Gynecologic History:

Age of first menstruation: _____ Have you ever been pregnant? NO /YES If so, How many times_____

Menopause? NO YES since age _____ How many children have you had? _____

First day of last menstrual period _____ Are they living? NO YES

How often do you get your period? _____ Have you had a miscarriage? NO YES How many? _____

How many days do your periods last? _____ Have you had an abortion? NO YES How many? _____

Do you bleed/spot between periods? NO YES Have you had an ectopic pregnancy? NO YES

Age at first intercourse: _____ Do you have adopted children? NO YES How many? _____

How many total sexual partners? _____ How many sexual partners in the past year? _____

Current method of birth control: _____

Obstetric History (list *all* deliveries, miscarriages, abortions):

Date:	# weeks	Sex	Vag/C-Sect	Weight	Complications
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____

Social History:

Marital Status: Single Married Divorced Widowed Domestic Partner

Do you currently smoke? NO Former (quit date): _____ YES How much per day? _____

Do you drink alcohol? NO YES How much/often? _____

Do you use illegal drugs? NO YES What, how often? _____

Do you exercise? NONE 1-2 times/week 3-4 times/week Almost Daily Daily

Do you perform monthly Self Breast Exams? NO YES

Have you experienced sexual or physical abuse in the past or present? NO YES

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Please circle any symptoms you are currently having or have recently experienced:

Weight Gain	Diarrhea	Leaking Urine	Frequent Bruising	Bleeding Easily
Weight Loss	Constipation	Vaginal Discharge	Frequent Headaches	Blood in Stools
Heavy Periods	Joint Pain	Breast Lumps	Nipple Discharge	Breast Pain
Chest Pain	Fainting	Shortness of Breath	Nausea/Vomiting	Abdominal Pain
Bloating	Skin Lesions	Change in Moles	Urinary Frequency	Urinary Urgency
Painful Urination	Irregular Periods	Painful Periods	Bleeding btwn Periods	Wheezing
Hot Flashes	Night Sweats	Excess Hair Growth	Painful Intercourse	Cough
Seasonal Allergies	Anxiety	Depression	Insomnia	

Any other concerns you may have, please list below:

_____

_____

_____

_____

_____

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