OBSTETRICS & GYNECOLOGY

NAME: _____ DATE OF BIRTH: _____

Please answer the following confidential questions about your health to help us better care for you.

Reason for this visit: _____

MENSTRUAL HISTORY

First day of last menstrual period: _____ Age at first period: _____

My periods are (chose one):

◯ Regular; and start every _____ days

◯ Irregular; and start every _____ to _____ days

How many days do you bleed for? _____ days Is the bleeding…. ◯ light? ◯ moderate? ◯ heavy?

Does bleeding/spotting occur between periods? ◯yes ◯no

Does bleeding/spotting occur after intercourse? ◯yes ◯no

Do you have pain associate with your periods?

◯ yes (check one) ___ before menses ___during menses ___both

◯ no

REPRODUCTIVE HISTORY

◯ NEVER BEEN PREGNANT

(Please include all pregnancies including miscarriages, terminations, and ectopic pregnancies

Pregnancy	Date	Hospital	Pregnancy Outcome	Complications	Birth Weight	Baby Name
#1						
#2						
#3						
#4						

BIRTH CONTROL HISTORY

Please circle the methods you currently use, underline the methods that you have used in the past.

Birth control pills	Depo-provera	Condoms	Tubal Ligation	None
Patch	Implanon	Sponge	Vasectomy	Abstinence
Vaginal Ring	IUD	Foam or gel		Rhythm method

SEXUAL HISTORY

Do you currently have a sexual partner? ◯yes ◯no

Are there concerns about your sexual activity which you want to discuss with your provider? ◯yes ◯no

PAST OB/GYN HISTORY

(check any that apply) ◯NONE

◯ D&C ◯ Myomectomy (fibroid removal) ◯ Vaginal or Bladder Repair

◯ Hysteroscopy ◯ Hysterectomy (uterus removal) ◯ Cesarean section

◯ Infertility Surgery ◯ Ovarian surgery ◯ Other _____

◯Laparoscopy ___ cyst removed right –or- left

___ ovary removed right –or- left

◯ Warts ◯ Endometriosis ◯Chlamydia ◯Genital

◯ Pelvic Inflammatory Disease ◯ Gonorrhea ◯ Syphilis ◯Vaginal Infection

Date of last pap smear _____ ◯ normal ◯ abnormal

Have you ever had an abnormal pap smear? ◯yes ◯no

If yes, check any procedures that you have had: □colposcopy □cyro/laser □ LEEP □Cone Biopsy

Date of last mammogram: _____ ◯ normal ◯ abnormal
Date of last colonoscopy: _____ ◯ normal ◯ abnormal
Date of last bone density:_____ ◯ normal ◯ abnormal

PAST SURGICAL HISTORY (not OBGYN)

◯ Thyroid surgery ◯ Appendectomy ◯ Bowel surgery ◯ Hernia surgery ◯ Bladder surgery
◯ Heart surgery ◯ Bone/Joint surgery ◯ Gall Bladder surgery ◯ Breast surgery ◯ Other:_____

PAST MEDICAL HISTORY

◯ Arthritis ◯Diabetes ◯High Blood Pressure ◯Heart Disease ◯Thyroid Disease
◯ Blood clotting Disorder (thrombophilia) ◯Kidney Disease ◯ Gallstones ◯ Liver Disease ◯ Asthma
◯Epilepsy/Seizures ◯Blood Transfusion ◯Other: _____

CURRENT MEDICATIONS (include type and amount)

_____ _____
_____ _____
_____ _____

ALLERGIES ◯ yes ◯ no

(please list) _____
_____
_____

DO YOU CURRENTLY ….

Smoke? ◯ yes ◯ no packs/day _____ Use illicit drugs? ◯ yes ◯no type_____
Use alcohol? ◯ yes ◯ no glasses or bottles/day __ Exercise? ◯yes ◯no how often_____

FAMILY HISTORY ◯NONE

◯Diabetes ◯Breast Cancer ◯Endometrial Cancer ◯Other: _____
◯Heart Disease ◯Ovarian Cancer ◯Colon Cancer _____
If you answered yes to any of the above – please list affected relatives_____
_____

OTHER SYMPTOMS (Have you experienced any of the following symptoms?)

◯ weight loss/gain ◯ change in exercise tolerance ◯ hot flushes
◯ abdominal bloating ◯ hair growth/loss ◯ breast discharge

Please tell us anything else about your history that would help us better care for you? _____
_____
_____

Please fill out the final section if you are **pregnant** or **planning to be pregnant** in the near future.

Have you, the baby's father, or anyone in your families ever had any of the following……?

◯ Down Syndrome? If yes, who? _____ ◯ Muscular dystrophy? _____
◯ Other chromosomal abnormality? _____ ◯ Cystic fibrosis? _____
◯ Neural tube defect (ex/spina bifida? _____ ◯ Mental retardation? _____
◯ Blood clotting or bleeding disorder? _____ ◯ Sickle cell trait or disease? _____
◯ Birth defects? _____ ◯ Alpha or Beta Thalassemia? _____

_____ _____
PATIENT SIGNATURE DATE