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

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

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

Medical History - Patient

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

Heart Disease	❍ Yes	❍ No	Migraines	❍ Yes	❍ No	HIV	❍ Yes	❍ No
Lupus	❍ Yes	❍ No	Thyroid Disease	❍ Yes	❍ No	Herpes	❍ Yes	❍ No
Arthritis	❍ Yes	❍ No	Cancer	❍ Yes	❍ No	Genital Warts	❍ Yes	❍ No
High Blood Pressure	❍ Yes	❍ No	Bleeding Tendencies	❍ Yes	❍ No	Chlamydia or Gonorrhea	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No	Lung Disease	❍ Yes	❍ No	Sickle Cell Disease or Trait	❍ Yes	❍ No
Kidney Disease	❍ Yes	❍ No	Chicken Pox	❍ Yes	❍ No	Anemia	❍ Yes	❍ No
Phlebitis or Blood Clots	❍ Yes	❍ No						

Please describe any "yes" answers. _____

_____

Medical History - Family

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

Office Use Only

Name _____ Patient # _____ Date _____

Medication (Prescription and Over the Counter)

Name	Dosage	Frequency	Name	Dosage	Frequency

Are you allergic to any medications? _____

Surgical History

Date	Procedure	Hospital	Surgeon

Obstetrical History

Date	Length of Pregnancy	Complications	D&C	Location

Deliveries

Date	Weight Gain	Length of Labor	Anesthesia (If Any)	Sex	Infant Weight	Complications

Office Use Only

Name _____ Patient # _____ Date _____

Social History

Do you ever feel unsafe at home? ❍ Yes ❍ No

Have you ever felt afraid of your partner? ❍ Yes ❍ No

Has anyone at home hit you or tried to injure you? ❍ 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? _____

Patient Signature _____ Date _____

Completed by (If other than patient) _____ Physician Signature _____

Date Reviewed _____ Physician Signature _____

Date Reviewed _____ Physician Signature _____

Date Reviewed _____ Physician Signature _____

Date Reviewed _____ Physician Signature _____

Date Reviewed _____ Physician Signature _____

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