advanced obgyn

Patient History

Name _____ Date of Birth _____

Reason for today's visit _____

Do you have/had any of the following medical illnesses?

- ❑ ASTHMA
- ❑ CANCER
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ HEART DISEASE
- ❑ HIGH BLOOD PRESSURE
- ❑ KIDNEY DISEASE
- ❑ THYROID DISEASE
- ❑ OTHER _____

List medications currently taking:

_____
_____

List all medication and foods you are allergic to:

_____
_____

List all hospitalizations and surgeries:

Date: Type of Surgery: Hospital:

_____
_____
_____

Gynecological History

Date of your last menstrual period: _____
How old were you when you had your first period? _____
Are your periods regular (every month)? _____
How many days does your period last? _____
Do you ever get pains during your period? _____
Have you received the Gardasil vaccine against HPV? _____
YES/NO Do you have spotting between periods?
YES/NO Do you have any pain with intercourse?
YES/NO Do you leak urine when you cough or sneeze?
YES/NO Do you have any burning with urination?

Have you ever been told that you had any of the following (circle)?
CHLAMYDIA GONORRHEA HERPES WARTS SYPHILIS HPV

When was your last pap smear (MO/DAY/YEAR)? _____
Was it normal? _____
When was your last mammogram? _____
When was your last colonoscopy? _____
When was your last bone density? _____

OB HISTORY

How many times total have you been pregnant? _____
Number of miscarriages _____ Number of abortions _____
Number of living children _____

Birth dates Length of preg. Birth weight Gender Mode of delivery Complications

_____
_____
_____
_____
_____

What type of contraception method do you use?

- ❑ CONDOMS
- ❑ ORAL PILLS
- ❑ PATCH
- ❑ RING
- ❑ DIAPHRAGM
- ❑ WITHDRAWL
- ❑ TUBAL LIGATION
- ❑ VASECTOMY
- ❑ IUD (MIRENA OR PARAGARD)
- ❑ IMPLANON

FAMILY HISTORY

- ❑ CANCER (BREAST, COLON, OVARIAN, UTERINE)
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ ELEVATED BLOOD PRESSURE
- ❑ THYROID PROBLEMS
- ❑ OSTEOPOROSIS

SOCIAL HISTORY

Do you smoke? _____
How many cigarettes/packs per day? _____
At what age did you start? _____
How many years have you been smoking? _____
Do you drink alcohol? _____
What do you normally drink? _____
Number of drinks per week? _____