

OB/Gyn History

Date: _____

Name _____ DOB _____

Menses/Birth Control

Age at onset of periods _____ 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 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 changes 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 Disorder	Yes	No	Chlamydia or Gonorrhea	Yes	No
Kidney Disease	Yes	No	Lung Disease	Yes	No	Sickle Cell Disease or Trait	Yes	No
Blood Clots	Yes	No	Chicken Pox	Yes	No	Anemia	Yes	No

Please describe any "yes" answers. _____

Medical History – Family

Family Member	Age	State of Health	Specific Disease	If Deceased, Age at time of death	If Deceased, Cause
_____	_____	Good Fair Poor _____	_____	_____	_____
_____	_____	Good Fair Poor _____	_____	_____	_____
_____	_____	Good Fair Poor _____	_____	_____	_____

Surgical History – Patient

Date	Procedure	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____

Name _____

Medication (Prescription and/or Over the Counter)

Name	Dosage	Frequency	Name	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you allergic to any medicine? _____

Obstetrical History

Have you ever been pregnant? Yes No (If No, proceed to Social History)

If yes, how many times have you been pregnant? _____ How many pregnancies did you carry to full term? _____

How many pre-term births? _____ Have you ever had an abortion or miscarriage? Yes No

How many living children do you have? _____

Deliveries

Date	Weight Gain	Length of Labor	Anesthesia (if any)	Sex of Baby	Infant Weight	Complications
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Social History

Do you ever feel unsafe at home? Yes No Has anyone at home hit you or tried to injure you? Yes No

Have you ever felt afraid of your partner? 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 smoke? _____

Do you drink alcohol? Yes No If yes, how much do you drink? _____

Do you use illicit or "street" drugs? Yes No If yes, what and how much do you use? _____

Are there other problems you need to discuss with your physician? _____

Signature of Patient or Person Completing Form (please state relationship to patient)

Date