Health History - OBGYN

Name: ______________________ **DOB:** ______________________ **Age:** ______________________

Preferred Name (Nickname): ______________________

Pharmacy Name: ______________________ **Pharmacy Address:** ______________________

PCP/Referring Provider Name: ______________________

List of all doctors you see: ______________________

Reason for today's visit: ______________________

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: ______________

Abnormal Pap Smear: ☐ Yes ☐ No Date: ______________

Last Mammogram Date: ______________

Abnormal Mammogram: ☐ Yes ☐ No Date: ______________

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _________

Last Bone Density Scan Date: ______________

Last Colonoscopy Date: ______________

Last Annual Exam Date: ______________

Current form of birth control (circle one):

Pills	Patch	Nuvaring	Depo-Provera	IUD	
Tubal ligation	Vasectomy	Condoms	Menopause	Hysterectomy	None

Number of pregnancies: _______ Births: _______ Miscarriages: _______ Abortions: _______

Date	Full/Preterm	Type of Delivery Abortion / Miscarriage Vaginal / C-section	Gender	Birth Weight
1st _______	Full / Pre	A / M / V / C	M / F	____ lbs ____ oz
2nd _______	Full / Pre	A / M / V / C	M / F	____ lbs ____ oz
3rd _______	Full / Pre	A / M / V / C	M / F	____ lbs ____ oz

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relationship
☐ Adopted	
☐ Alcoholism	
☐ Anemia	
☐ Aneurysm	
☐ Anxiety Disorder	
☐ Blood Clots/DVT	
☐ Blood Clotting Disorder	
☐ Breast Cancer	
☐ Colon Cancer	
☐ Dementia	
☐ Depressive Disorder	
☐ Diabetes Mellitus	
☐ Emphysema	
☐ Family History of Cancer	

	Relationship
☐ Gastrointestinal Disease	
☐ Heart Disease/Heart Attack	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Hypothyroidism	
☐ Kidney Disease	
☐ Migraine	
☐ Osteoporosis	
☐ Ovarian Cancer	
☐ Pulmonary Embolism	
☐ Seizure Disorder	
☐ Stroke	
☐ Substance Abuse	

SOCIAL HISTORY

Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Tobacco Use	☐ Yes ☐ No	Packs per day__________	
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____		
Illicit Drug Use	☐ Yes ☐ No	Drug Abuse Type:	Illicit Drugs Years of use:
Patient Occupation: ________________________		Do you feel safe in your home? ________________________	

PAST SURGICAL HISTORY Have you ever had the following:

	YEAR
☐ Abdominal Surgery	
☐ Appendectomy	
☐ Back Surgery	
☐ Bariatric Surgery	
☐ Bilateral Mastectomy	
☐ Bladder Surgery	
☐ Breast Biopsy	
☐ Breast Implants	
☐ Breast Surgery	
☐ Cancer Surgery	
☐ Cesarean Section	

	YEAR
☐ Circumcision	
☐ Colon Surgery	
☐ Cystoscopy	
☐ Dilation and Curettage	
☐ Endometrial Ablation	
☐ Fallopian Tube Removal	
☐ Gallbladder Surgery	
☐ Gastrointestinal Surgery	
☐ Gyn Surgery	
☐ Hernia Repair	
☐ Hysterectomy-Partial	

	YEAR
☐ Hysterectomy-Total	
☐ Hysteroscopy	
☐ Kidney Surgery	
☐ Laparoscopy	
☐ LEEP	
☐ Mastectomy	
☐ Orthopedic Surgery	
☐ Ovarian Cystectomy	
☐ Ovary Removal	
☐ Plastic Surgery	
☐ Sinus Surgery	

	YEAR
☐ Small Bowel Resection	
☐ Thyroid Surgery	
☐ Tonsillectomy	
☐ Tubal Ligation	
☐ Urologic Surgery	

PAST MEDICAL HISTORY Have you ever had the following:

	DATE
☐ Anemia	
☐ Asthma	
☐ Bleeding Disorder/DVT	
☐ Cancer (specify)	
☐ Depression	
☐ Diabetes Type 1	
☐ Diabetes Type 2	
☐ Endometriosis	
☐ Epilepsy	
☐ Fibroids	
☐ Heart Disease	
☐ High Cholesterol	

	DATE
☐ Hypertension/High Blood Pressure	
☐ HPV	
☐ Intestinal Disorder	
☐ MRSA	
☐ Migraines	
☐ Osteoporosis	
☐ STDs	
☐ Stroke/TIA	
☐ Thyroid Disorder	
☐ Other Disease(s):	

Review of Systems

Check all that apply:

Constitutional

☐ Yes ☐ No Fatigue
☐ Yes ☐ No Fever
☐ Yes ☐ No Weight Gain
☐ Yes ☐ No Weight Loss

Skin

☐ Yes ☐ No Abnormal Moles
☐ Yes ☐ No Rashes

Eyes

☐ Yes ☐ No Irritation
☐ Yes ☐ No Vision Changes

ENMT

☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Ear Pain
☐ Yes ☐ No Nose/Sinus Problems
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Snoring
☐ Yes ☐ No Dry Mouth
☐ Yes ☐ No Mouth Ulcers

Respiratory

☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Cough
☐ Yes ☐ No Sputum Production
☐ Yes ☐ No Coughing up Blood
☐ Yes ☐ No Wheezing

Cardiovascular

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Shortness of Breath while Walking/Lying Flat

Gastrointestinal

☐ Yes ☐ No Heartburn
☐ Yes ☐ No Difficulty Swallowing
☐ Yes ☐ No Nausea
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Bowel Movement Changes
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Rectal Bleeding

Genitourinary

☐ Yes ☐ No Blood in Urine
☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Flank Pain
☐ Yes ☐ No Trouble Urinating
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Rash
☐ Yes ☐ No Lesion
☐ Yes ☐ No Discharge
☐ Yes ☐ No Vaginal Odor
☐ Yes ☐ No Vaginal Itching

Breast

☐ Yes ☐ No Breast Pain
☐ Yes ☐ No Masses
☐ Yes ☐ No Changes in Skin
☐ Yes ☐ No Change in Nipple Appearance
☐ Yes ☐ No Nipple Discharge
☐ Yes ☐ No Axillary Pain/Masses

Endocrine

<u>Menstrual</u>

☐ Yes ☐ No Menstrual Problems
☐ Yes ☐ No PMDD
☐ Yes ☐ No Mood Swings
☐ Yes ☐ No Irritability
☐ Yes ☐ No Tension/Anxiety
☐ Yes ☐ No Depressed Mood
☐ Yes ☐ No Breast Pain/Tenderness
☐ Yes ☐ No Bloating
☐ Yes ☐ No Overwhelmed
☐ Yes ☐ No Headache
☐ Yes ☐ No Cramping

<u>Menopausal</u>

☐ Yes ☐ No Hot Flashes
☐ Yes ☐ No Night Sweats
☐ Yes ☐ No Dry Vagina Mucosa
☐ Yes ☐ No Impaired Memory
☐ Yes ☐ No Impaired Concentration

<u>Sexual</u>

☐ Yes ☐ No Decreased Libido
☐ Yes ☐ No Orgasmic Dysfunction
☐ Yes ☐ No Painful Intercourse
☐ Yes ☐ No Difficult Penetration

Musculoskeletal

☐ Yes ☐ No Muscle Aches
☐ Yes ☐ No Muscle Weakness
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Back Pain

Neurological

☐ Yes ☐ No Headaches
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Loss of Consciousness
☐ Yes ☐ No Numbness
☐ Yes ☐ No Seizure

Psychological

☐ Yes ☐ No Depression
☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Trouble Sleeping
☐ Yes ☐ No Back Pain

Hematologic/Lymphatic

☐ Yes ☐ No Swollen Glands
☐ Yes ☐ No Bruising
☐ Yes ☐ No Excessive Bleeding

Allergic/Immunologic

☐ Yes ☐ No Runny Nose
☐ Yes ☐ No Itching
☐ Yes ☐ No Hives
☐ Yes ☐ No Frequent Sneezing