Ob-Gyn Associates Women's Health History Form

Name: ____________________ Age: ______ Marital Status: ________

Referred by: ________________ Reason for visit: ____________________

Medical & Family History

Have you or any members of your family had:

	SELF	FAMILY
High Cholesterol	☐	☐
Heart disease	☐	☐
High blood press.	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Intestinal problems	☐	☐
Breast problems	☐	☐
Bladder problems	☐	☐
AIDS (HIV)	☐	☐
Hepatitis	☐	☐
Blood disorder	☐	☐
Infertility	☐	☐
Endometriosis	☐	☐
Osteoporosis	☐	☐
Lupus	☐	☐
Blood transfusion	☐	☐
Seizures	☐	☐
Migraines	☐	☐
Depression	☐	☐
Domestic Violence	☐	☐
Abnormal Pap smear	☐	☐
Abnormal mammogram	☐	☐
Genital warts	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐
Gonorrhea	☐	☐
Sexual problems	☐	☐
DES Exposure	☐	☐

PREGNANCY HISTORY

of full term births ______

# of premature births ______

# of miscarriages ______

# of terminations ______

# of living children ______

Please list all the **MEDICATIONS** you are currently taking including over the counter medications and vitamins:

____

____

____

____

____

____

Please list any **ALLERGIES** to medications:

____

____

____

____

MENSTRUAL HISTORY

Age at first period ________

First day of last period ____

days between periods ____

days of flow__________

Any excessive bleeding? ____

Any excessive cramping? ____

Any bothersome discharge?

Any vaginal itching? _______

Date of last Pap smear _____

Date of last mammogram ____

CONTRACEPTIVE HISTORY

	PRESENT	PAST
Birth Control pill	☐	☐
IUD	☐	☐
Diaphragm	☐	☐
Condoms	☐	☐
Spermacides	☐	☐
Norplant	☐	☐
Depo-Provera	☐	☐
Vasectomy	☐	☐
Tubal Ligation	☐	☐

HOSPITALIZATIONS

Please list any operations or serious illnesses requiring hospitalization:

Month/year Illness/Operations

____

____

____

____

____

____

LIFESTYLE

How many alcoholic drinks do you have a day? ________

How many cigarettes do you smoke a day? __________

Do you use any street drugs like cocaine or marijuana? _____

How many caffeinated drinks do you have a day? __________

How many glasses of milk do you have a day? __________

Do you take Calcium supplements? __________

How many times a week do you exercise? ___________

Do you perform breast self-exam? ____________

Do you feel that you are engaging in risky sexual behavior? ________

Are you currently experiencing any **OTHER PROBLEMS** not mentioned above?

____

____

____

____

____