

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 | FAM |
|---------------------|--------------------------|--------------------------|
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood press. | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Intestinal problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS (HIV) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Domestic Violence | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal mammogram | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital warts | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| Chlamydia | <input type="checkbox"/> | <input type="checkbox"/> |
| Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual problems | <input type="checkbox"/> | <input type="checkbox"/> |
| DES Exposure | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| IUD | <input type="checkbox"/> | <input type="checkbox"/> |
| Diaphragm | <input type="checkbox"/> | <input type="checkbox"/> |
| Condoms | <input type="checkbox"/> | <input type="checkbox"/> |
| Spermicides | <input type="checkbox"/> | <input type="checkbox"/> |
| Norplant | <input type="checkbox"/> | <input type="checkbox"/> |
| Depo-Provera | <input type="checkbox"/> | <input type="checkbox"/> |
| Vasectomy | <input type="checkbox"/> | <input type="checkbox"/> |
| Tubal Ligation | <input type="checkbox"/> | <input type="checkbox"/> |

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?

