# OB / GYN HISTORY FORM

## COMPLETE BOTH SIDES

| Name: | Age: | LABEL |
|---|---|---|
| Weight: | Height: | |
| Reason for Visit? | | |

**(do not write in this space)**

### Past Medical History

| | | |
|---|---|---|
| *Diabetes* *D Yes D No*<br>*Comments* | *Thyroid Problems* *D Yes D No*<br>*Comments* | *Gastrointestinal* *D Yes D No*<br>*Comments* |
| *High Blood Pressure* *D Yes D No*<br>*Comments* | *Urinary Tract Infections* *D Yes D No*<br>*Comments* | *Neurologic/Epilepsy* *D Yes D No*<br>*Comments* |
| *Heart Disease* *D Yes D No*<br>*Comments* | *Blood Clots Leg/Lung* *D Yes D No*<br>*Comments* | *Hepatitis/Liver Disease* *D Yes D No*<br>*Comments* |
| *Kidney Disease* *D Yes D No*<br>*Comments* | *Asthma* *D Yes D No*<br>*Comments* | *Psychiatric* *D Yes D No*<br>*Comments* |
| **Surgeries** (Reason & Year)<br>1 | **Other Medical Problems**<br>1 | **Hospitalizations** (Reason & Year)<br>1 |
| 2 | 2 | 2 |
| 3 | 3 | 3 |
| 4 | 4 | 4 |

### Past Gynecologic History

| | | |
|---|---|---|
| Last menstrual period | | Sexually Active: D Yes D No |
| Duration of flow (days): | Light \| Mod \| Heavy | Your partner is: D Male D Female D Both |
| Cramps? None I Mild I Mod I Severe | Clots? *D Yes D No* | Contraception: |
| Time between periods: | | Last Pap: |
| Last Mammogram: | | History of Abnormal Pap? |

| Please check if you have or previously had the following | Comments |
|---|---|
| D Abnormal Vaginal Bleeding | |
| D Sexually Transmitted Disease | D Herpes D Gonorrhea D Chlamydia D HPV D Syphilis D HIV |
| D Incontinence/Leakage of Urine | D Prolapse Bladder I Rectum I Uterus |

**CONTINUE ON BACK SIDE**

**Past Obstetrical History** - To include **ALL** vaginal births, C-Sections, miscarriages, ectopics and abortions.

| Date (Mo. / Yr.) | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Birth Weight | | | | | | |
| Type of delivery (Vaginal / C-sect.) | | | | | | |
| Complications | | | | | | |

| **Medications & Dosage -** Include Vitamins/Herbs | **Allergies - List Reaction** |
|---|---|
| | |
| | |
| | |
| | |

## Social History

| Occupation | Marital Status<br>D Single D Married D Divorced | Social Drug Use D Yes D No Type:<br>Amount: How often: |
|---|---|---|
| Cigarettes D Yes D No<br>For how long: | Pack/day:<br>Quit date: | **Spouses** Name / Age / Occupation: |
| Alcohol D Yes D No<br>Amount: | Type:<br>How often: | |

## Family History

| | | | |
|---|---|---|---|
| Breast Cancer<br>Who: | D Yes D No | High Blood Pressure<br>Who: | D Yes D No |
| Ovarian Cancer<br>Who: | D Yes D No | Heart Disease<br>Who: | D Yes D No |
| Uterine Cancer<br>Who: | D Yes D No | Diabetes<br>Who: | D Yes D No |
| Colon Cancer<br>Who: | D Yes D No | Psychiatric Disorder<br>Who: | D Yes D No |
| Osteoporosis<br>Who: | D Yes D No | Gynecological Problems<br>Who: | D Yes D No |

**Exam/ Plan:**