OBGYN West Health History Form

Office Patient ID #____________

Please fill in all information on front and back of form

Today's Date________________

Name____ Date of Birth _____/_____/_________

Referred by ___________________________________ Primary Care Doctor ___________________________________

Reason for today's visit ____

Menstrual History

First day of last period ______/______/______ Age at first period _______

Your periods occur every _______________days and last for __________days

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy flow ☐ Clots ☐ Pain/Cramping ☐ Irregular periods ☐ Discharge

☐ Bleeding between periods ☐ Other__________________________________

If menopausal

Age/year began_____________ Any Postmenopausal bleeding? ☐ No ☐ Yes

Gynecological History

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear ☐ Breast Pain ☐ Chronic Pelvic Pain

☐ DES Exposure ☐ Endometriosis ☐ Genital Warts

☐ Infertility ☐ Ovarian Cysts ☐ Pain with Intercourse

☐ PID ☐ PMS ☐ Recurrent Miscarriage

☐ Recurrent Vaginitis ☐ STD ________________________________

☐ Urinary Incontinence ☐ UTI (chronic) ☐ Uterine Fibroids

☐ **None of the above** *(additional medical history on the back of form)*

Contraceptive History

Are you currently sexually active? ☐ Yes ☐ No ☐ Never been

How many life time partners? _________ How many in the last year?______

Current method of birth control (Include tubal or vasectomy) _______________

Any problems with current method? ☐ No ☐ Yes ____________________

Previously used methods (Check all that apply)

☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ Depo Provera ☐ IUD

☐ NuvaRing ☐ Implanon ☐ Nexplanon ☐ Spermicide ☐ Sponge ☐ Other

☐ No previous birth control

Preventive Care History

Last Pap Smear Date:______________________ ☐ Normal ☐ Abnormal

Last Mammogram Date: ___________________ ☐ Normal ☐ Abnormal

Last Colonoscopy Date:____________________ ☐ Normal ☐ Abnormal

Last DEXA (Bone Scan) Date: _______________ ☐ Normal ☐ Abnormal

Last Cholesterol Test Date:_________________ ☐ Normal ☐ Abnormal

Vaccinations (year) Gardasil __________ Flu ___________

Herpes Zoster (Shingles) __________ TDAP (Tetanus) ___________

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Surgical History (Please list all surgical procedures) ☐ **None**

Surgery________________________________ Date______________

Surgery________________________________ Date______________

Surgery________________________________ Date______________

Surgery________________________________ Date______________

Surgery________________________________ Date______________

Allergy History (List all medication allergies and reaction) ☐ **None**

Allergy___________________________ Reaction_________________________

Allergy___________________________ Reaction_________________________

Allergy___________________________ Reaction_________________________

Allergy___________________________ Reaction_________________________

Allergy___________________________ Reaction_________________________

Current Medication History

(Please include current prescriptions and medications ONLY) ☐ **None**

Drug name______________________________ Dose_____________

Drug name______________________________ Dose_____________

Drug name______________________________ Dose_____________

Drug name______________________________ Dose_____________

Drug name______________________________ Dose_____________

Drug name______________________________ Dose_____________

Social & Lifestyle History

Marital Status ________________ Occupation______________________

Tobacco Smoker ☐ Never ☐ Former ☐ Current - Amt/Day_______________

Alcohol Use ☐ No ☐ Yes If yes, Amt/Wk_____________

Caffeine Use ☐ No ☐ Yes Street Drugs/Marijuana use ☐ No ☐ Yes

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Regular Exercise ☐ No ☐ Yes Type________________ Amt/Wk________

Monthly Breast Exam☐ No ☐ Yes Have you had Chicken Pox ☐ No ☐ Yes

Do you have a Health Care Directive (living will) ☐ No ☐ Yes

Past Medical History

Indicate Relationship

Condition	Self	Family	
Anemia	☐ Self	☐ Family	->
Anxiety	☐ Self	☐ Family	->
Asthma	☐ Self	☐ Family	->
Blood Clotting Disorder	☐ Self	☐ Family	->
Cancer; Breast	☐ Self	☐ Family	->
Cancer; Cervical	☐ Self	☐ Family	->
Cancer; Colon	☐ Self	☐ Family	->
Cancer; Ovarian	☐ Self	☐ Family	->
Cancer; Skin-type:________________	☐ Self	☐ Family	->
Cancer; Uterine	☐ Self	☐ Family	->
Cancer; Other ->	☐ Self	☐ Family	->
Cardiac Arrhythmia	☐ Self	☐ Family	->
Coronary Artery Disease	☐ Self	☐ Family	->
Crohn's Disease	☐ Self	☐ Family	->
Cystic Fibrosis	☐ Self	☐ Family	->
Deep Vein Thrombosis (DVT)	☐ Self	☐ Family	->
Depression	☐ Self	☐ Family	->
Diabetes-type:____________________	☐ Self	☐ Family	->
Eating Disorder-type:_______________	☐ Self	☐ Family	->
Gastric Ulcer	☐ Self	☐ Family	->
Gastroesophageal Reflux Disease	☐ Self	☐ Family	->
Gestational Diabetes	☐ Self	☐ Family	->
Hepatitis-type:____________________	☐ Self	☐ Family	->
Hyperlipidemia (High Cholesterol)	☐ Self	☐ Family	->
Hypertension (High Blood Pressure)	☐ Self	☐ Family	->
Irritable Bowel Syndrome	☐ Self	☐ Family	->
Kidney Stones	☐ Self	☐ Family	->
Lupus	☐ Self	☐ Family	->
Migraines	☐ Self	☐ Family	->
Multiple Sclerosis	☐ Self	☐ Family	->
Osteoporosis	☐ Self	☐ Family	->
Parkinson's Disease	☐ Self	☐ Family	->
Pulmonary Embolism	☐ Self	☐ Family	->
Rheumatoid Arthritis	☐ Self	☐ Family	->
Scoliosis	☐ Self	☐ Family	->
Seizures	☐ Self	☐ Family	->
Sickle - Cell Disease	☐ Self	☐ Family	->
Sleep Apnea/Disorder	☐ Self	☐ Family	->
Stroke	☐ Self	☐ Family	->
Thyroid Disorder-type:_____________	☐ Self	☐ Family	->
Tuberculosis	☐ Self	☐ Family	->
Ulcerative Colitis	☐ Self	☐ Family	->

Other Medical History we should know about ->

Are there any other problems that are important to you today?

☐ No ☐ Yes ____

____

____

Patient Signature:_________________________________

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

System	Symptom	Yes	No
Constitutional	Fever	☐ Yes	☐ No
	Chills	☐ Yes	☐ No
	Sweats	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Weight gain	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No
Eyes	Impaired Vision	☐ Yes	☐ No
Head, Ears, Nose, & Throat	Headaches	☐ Yes	☐ No
	Sinus Congestion	☐ Yes	☐ No
Breast	Lumps	☐ Yes	☐ No
	Tenderness	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Nipple Discharge	☐ Yes	☐ No
Cardiovascular	Chest pain	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No
Respiratory	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Cough	☐ Yes	☐ No
Gastrointestinal	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Blood in stools	☐ Yes	☐ No
Genitourinary	Urinary urgency	☐ Yes	☐ No
	Urinary frequency	☐ Yes	☐ No
	Urinary Incontinence	☐ Yes	☐ No
	Blood in urine	☐ Yes	☐ No
Integument (Skin)	Rash	☐ Yes	☐ No
	Change in moles, lesions	☐ Yes	☐ No
	Change in hair growth/loss	☐ Yes	☐ No
Neurologic	Muscular weakness	☐ Yes	☐ No
	Incoordination	☐ Yes	☐ No
	Tingling or numbness	☐ Yes	☐ No
Musculoskeletal	Joint pain	☐ Yes	☐ No
	Muscle pain	☐ Yes	☐ No
Endocrine	Excessive thirst	☐ Yes	☐ No
	Excessive urination	☐ Yes	☐ No
	Temperature intolerance	☐ Yes	☐ No
Psychiatric	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Feeling Confused	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No
	Excessive Anger	☐ Yes	☐ No
Heme-Lymph	Easy bleeding	☐ Yes	☐ No
	Easy bruising	☐ Yes	☐ No
	Swollen lymph glands	☐ Yes	☐ No
Allergic-Immunologic	Sinus allergy symptoms	☐ Yes	☐ No
	Frequent illnesses	☐ Yes	☐ No

Reviewed by:________________________________