Health History - OBGYN

Name: ____________________ **DOB:** ____________
Preferred Name (Nickname): ____________________
Pharmacy Name: ____________________ **Pharmacy Address:** ____________________
PCP/Referring Provider Name: ____________________
List of all doctors you see (Care Team): ____________________

Reason for today's visit: ____________________
When did your symptoms begin? ____________________
What triggers your symptoms? ____________________
What makes your symptoms better? ____________________
Grade your pain 0-10 (0= no pain and 10=worst pain): ____________________
What treatment have you had for your symptoms? ____________________

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

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

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

	Relation		Relation
☐ Adopted		☐ Gastrointestinal Disease	
☐ Alcoholism		☐ Heart Disease/Heart Attack	
☐ Anemia		☐ High Blood Pressure	
☐ Aneurysm		☐ High Cholesterol	
☐ Anxiety Disorder		☐ Hypothyroidism	
☐ Blood Clots/DVT		☐ Kidney Disease	
☐ Blood Clotting Disorder		☐ Migraine	
☐ Breast Cancer		☐ Osteoporosis	
☐ Colon Cancer		☐ Ovarian Cancer	
☐ Dementia		☐ Pulmonary Embolism	
☐ Depressive Disorder		☐ Seizure Disorder	
☐ Diabetes Mellitus		☐ Stroke	
☐ Emphysema		☐ Substance Abuse	
☐ Family History of Cancer			

SOCIAL HISTORY

Marital Status	☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed
Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? ______________ Year Quit: ___________ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/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)? ____
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day ______________
Illicit Drug Use/Abuse	☐ Yes ☐ No Drug Abuse Type: _________________ Illicit drug years of use: __________________
Employment	Occupation: Employer:
Do you feel safe in your home?	
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year		Year		Year
☐ Abdominal Surgery		☐ Circumcision		☐ Hysterectomy-Total		☐ Small Bowel Resection	
☐ Appendectomy		☐ Colon Surgery		☐ Hysteroscopy		☐ Thyroid Surgery	
☐ Back Surgery		☐ Cystoscopy		☐ Kidney Surgery		☐ Tonsillectomy	
☐ Bariatric Surgery		☐ Dilation and Curettage		☐ Laparoscopy		☐ Tubal Ligation	
☐ Bilateral Mastectomy		☐ Endometrial Ablation		☐ LEEP		☐ Urologic Surgery	
☐ Bladder Surgery		☐ Fallopian Tube Removal		☐ Mastectomy			
☐ Breast Biopsy		☐ Gallbladder Surgery		☐ Orthopedic Surgery			
☐ Breast Implants		☐ Gastrointestinal Surgery		☐ Ovarian Cystectomy			
☐ Breast Surgery		☐ Gyn Surgery		☐ Ovary Removal			
☐ Cancer Surgery		☐ Hernia Repair		☐ Plastic Surgery			
☐ Cesarean Section		☐ Hysterectomy-Partial		☐ Sinus Surgery			

Any other Medical/Surgical history/conditions, please inform the nurse.

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
Anemia	☐	☐	Hypertension/High Blood Pressure	☐	☐
Asthma	☐	☐	HPV	☐	☐
Bleeding Disorder/DVT	☐	☐	Intestinal Disorder	☐	☐
Cancer (specify)	☐	☐	MRSA	☐	☐
Depression	☐	☐	Migraines	☐	☐
Diabetes Type 1	☐	☐	Osteoporosis	☐	☐
Diabetes Type 2	☐	☐	STDs	☐	☐
Endometriosis	☐	☐	Stroke/TIA	☐	☐
Epilepsy	☐	☐	Thyroid Disorder	☐	☐
Fibroids	☐	☐	Other Disease(s):	☐	☐
Heart Disease	☐	☐			
High Cholesterol	☐	☐			

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