

Medical History – OB/Gyn

General Information

Name: _____ DOB: __/__/____ Age: _____

Sex: M F Language(s) spoken: English Spanish Polish Other: _____

Date (today): __/__/____

Reason for today's visit: _____

Medical History (Check all current or past problems.)

- | | | | |
|----------------------|----------------------|-----------------------|------------------------------------|
| Anemia | Eating Disorder | High blood pressure | Sleep problems |
| Arthritis | Gall bladder | High cholesterol | Stomach/digestive disease |
| Bleeding disorder | disease/stones | HIV/AIDS | Stroke |
| Blood transfusion | Headaches/migraine | Kidney disease/stones | Stroke |
| Bone/joint injuries | Heart disease | Liver disease | Thyroid disease |
| Cancer | Heart rhythm problem | Lung disease/Asthma | Tuberculosis (or positive TB test) |
| Convulsions/seizures | Hemorrhoids | Osteoporosis | Urinary problem |
| Diabetes | Hepatitis | Pneumonia | |
| Depression/Anxiety | Hernia | Sexual problems | |

Please give details of any items checked, or add information about other problems if they are not listed:

Obstetric/Gynecologic History:

First day/date of last period: _____ Age periods began: _____

If you no longer have periods, how old were you when they stopped? _____

Number of days you usually bleed with period: _____ Number of days between periods: _____

Have you had any recent change in your periods? Yes No If yes, what change? _____

Are you sexually active? Yes No Are your partners? Men Women Both

Age of first sexual intercourse: _____ Numbers of sexual partners in lifetime? _____

Are you using birth control? Yes No If yes, what type? _____

Have you ever had a sexually transmitted disease? Yes No If yes, what type(s)? _____

Total # of pregnancies? _____ Abortions? _____ Miscarriages? _____ # live children? _____

Pregnancies (Please list details of all your pregnancies):

Date	Sex (M/F)	Birth Weight	Number of weeks	Type of Delivery	Complications

Surgical History (List the date and type of any past surgeries)

Date	Surgery	Date	Surgery

Medications:

List any medications, prescription or non-prescription, including the dose and how often you take it. Please include all types of medicine, including pills, injections creams and eye drops.

Medication	Dose and Frequency	Medication	Dose and Frequency

Are you taking or using anything else for your health or to treat symptoms (such as vitamins, herbs or weight loss products)? If so, please list them: _____

Allergies and Adverse Reactions (List any substances that have caused a bad reaction, and write the reaction. Please include prescription or non-prescription medicines, foods, plants or other materials.)

Substance	Reaction	Substance	Reaction

Personal History and Habits (Your responses will be kept confidential.)

Are you employed? Yes No Occupation: _____
 Are you? Single Married Divorced Widowed
 Who lives with you in your home? _____
 At home, do you need help getting around, dressing, bathing, using the bathroom, or eating? Yes No
 If yes, what do you need help with? _____
 Do you exercise? Yes No If yes, what activities and how often? _____
 When was your last dental exam? _____ Do you wear dentures? Yes No
 When was your last vision exam? _____ Do you wear glasses or contact lenses? Yes No
 Have you recently or do you often travel outside the U.S.? Yes No If so, where? _____

Substances

Do you use tobacco? Yes No If no, have you ever used tobacco? Yes No
 If yes, what type? Cigarettes How much and for how long: _____
 Cigars How much and for how long: _____
 Chewing tobacco How much and for how long: _____
 In the past year, have you ever drunk or used drugs more than you meant to? Yes No
 In the past year, have you ever thought you should cut down on your drinking or drug use? Yes No
 Do you ever get annoyed or angry when people talk to you about your drinking/drug use? Yes No
 Do you ever feel guilty about your drinking/drug use? Yes No
 Have you ever had an “eye-opener” (morning drink) to get started first thing in the morning? Yes No
 About how many alcohol-containing drinks do you have in a typical week? (One drink is 12 oz. beer, 5 oz. wine, or 1 shot of liquor) 1-7 8-10 11-13 14-20 21-30 31-40 41 or more

Safety

- Have you had any falls within the past 6 months? Yes No
 Do you use a cane, walker or other device to help you get around? Yes No
 Do you feel unsafe or threatened in any way (at home, work or otherwise)? Yes No
 Have you ever been the victim of violence or abuse (including sexual abuse)? Yes No
 Do you or other family members keep gun(s) in the home? Yes No
 Do you wear a seatbelt when you drive? No Yes Sometimes
 Do you have smoke detector(s) in your home? No Yes Don't know

Nutrition

What is your usual weight? _____ What is your usual height? _____

- Have you unintentionally gained or lost 10 pounds in the last month? Yes No How much? _____
 Have you had decreased food intake for more than one week? Yes No
 Do you have difficulty swallowing? Yes No
 Do you have any pressure sores or skin ulcers? Yes No
 Are you on a modified or special diet, or on tube feeding? Yes No
 If yes, please describe: _____

Are you pregnant or breast-feeding? Yes No

Family History (Please write which family member(s) have or had the following):

Illness	Family Member(s)	Illness	Family Member(s)
Alcohol / substance abuse		High cholesterol	
Cancer; type? _____		Psychiatric illness	
Diabetes		Stroke	
Heart disease/attack		Tuberculosis	
High blood pressure		Other:	

Cancer Screening

Colon cancer (over age 50):

Have you ever had a test to see if you had colon cancer? Yes No Don't know

Cervical Cancer

When was your last Pap smear (year)? _____ Don't remember Never had one
 Have you ever had an abnormal Pap smear? Yes No Don't know

Breast Cancer

When was your last mammogram (year)? _____ Don't remember Never had one
 Have you ever had an abnormal mammogram? Yes No Don't know

Immunizations (Have you ever had the following):

Tetanus booster: Yes, Year: _____ Never Don't know
 Flu vaccine: Yes, Year: _____ Never Don't know
 Pneumonia vaccine: Yes, Year: _____ Never Don't know

SYMPTOMS - Review of Systems:

Please check all that apply to you

CONSTITUTIONAL:

- Fever
- Night sweats
- Weight gain lbs _____
- Weight loss lbs _____
- Exercise intolerance

EYES:

- Dry eyes
- Irritation
- Vision change

EARS, NOSE MOUTH, THROAT:

- Difficulty hearing
- Ear pain
- Frequent nosebleeds
- Nose/sinus problems
- Sore throat
- Bleeding gums
- Snoring
- Dry mouth
- Oral abnormalities
- Mouth ulcer
- Teeth abnormalities

CARDIOVASCULAR:

- Chest pain on exertion
- Arm pain on exertion
- Shortness of breath when walking
- Shortness of breath when lying down
- Palpitations
- Known heart murmur
- Light-headed on standing

RESPIRATORY:

- Cough
- Wheezing
- Shortness of breath
- Coughing up blood
- Sleep apnea

GASTROINTESTINAL:

- Abdominal pain
- Heartburn
- Vomiting
- Change in appetite
- Black or tarry stools
- Diarrhea
- Constipation
- Vomiting blood

GENITOURINARY:

- Urinary loss
- Difficulty urinating
- Increased urinary frequency
- Blood in urine (hematuria)
- Incomplete emptying

URINARY FEMALE:

- Abnormal vaginal discharge
- Bleeding between periods
- Breast lump
- Hot flashes
- Irregular periods
- Painful intercourse
- Severe menstrual pain
- Sore(s) on genitals

URINARY MALE:

- Lump in testicle
- Penis discharge
- Sore(s) on genitals
- Inadequacy of penile erection

MUSCULOSKELETAL:

- Muscle aches
- Muscle weakness
- Joint pain
- Back pain
- Edema

INTEGUMENTARY/SKIN:

- Abnormal mole
- Jaundice
- Rash
- Nail problem
- Itching
- Dry skin
- Growths/lesions

NEUROLOGIC:

- Loss of consciousness
- Weakness
- Numbness
- Memory/Loss
- Seizures
- Dizziness
- Headaches
- Migraine
- Restless legs

PSYCHIATRIC:

- Depression
- Anxiety
- Sleep disturbances/restless sleep
- Feel unsafe in a relationship
- Alcohol overuse

ENDOCRINE:

- Fatigue
- Increased thirst
- Hair loss
- Increased hair growth
- Cold intolerance

HEMATOLOGIC/LYMPHATIC:

- Swollen glands
- Easy bruising
- Excessive bleeding

ALLERGIC/IMMUNOLOGIC:

- Runny nose
- Sinus pressure
- Itching
- Hives
- Frequent sneezing

Reviewed by:

PHYSICIAN

DATE