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Obstetrics and Gynecology

Date:

Name:

Age: **Date of Birth:**

Date that Last Menstrual Period Began:

Number of Previous Pregnancies: **Number of Full Term Deliveries:**

What do you currently use for contraception?:

I. Reason for Today's Visit:

_____

_____

II. Past Medical History (Include dates, diagnoses, treatments)

a. **Any prior surgeries?:**
b. **List any Hospitalization you have had:**
c. **List all Medical Problems:**
d. **List all Medications you are currently taking:**
e. **List all Medications to which you are Allergic:**
f. **Have you ever had any Blood Transfusions:**

III. Social History

a. **Marital Status:**
b. **What kind of work do you do?:**
c. **Do you smoke cigarettes?:**
d. **Do you drink alcohol?:**

IV. Family History

a. **Health of Mother, Father and Siblings:**
b. **In your Family, is there a History of:**

Breast Cancer: **High Blood Pressure:**

Diabetes: **Osteoporosis:**

Tuberculosis: **Colon Cancer:**

Ovarian Cancer: **Heart Disease:**

V. Review of Systems (Include dates, diagnosis, treatments)

a. Heart problems?

b. Lung Problems?

c. Digestion Problems?

d. Urination Problems?

e. Hormone Problems?

f. Musculoskeletal Problems?

g. Psychiatric Problems?

h. Other Problems?

VI. Obstetrical History

a. How many Premature Deliveries?

b. How many Miscarriages?

c. How many Abortions?

d. How many Living Children?

e. How many of your Children were born by Cesarean Section?

f. Were all your Children Normal at Birth?

g. Have you had any Serious Complications with any Previous Pregnancies?

VII. Gynecological History

a. Age of your First Period? Length of Cycles? Days of Flow?

Do you have Cramps? Are they Severe?

Amount of Menstrual Flow? Heavy? Average? Light?

Do you have Premenstrual Water Retention or Mood Changes?

Do you ever have Irregular Menstrual Cycles?

b. Any History of Bleeding between Periods?

Any History of Bleeding after Intercourse?

Any History of Abnormal Pap Smears?

Any History of Excessive Vaginal Infections?

Any History of Painful Intercourse?

Any History of Breast Problems?

Any History of Sexual Problems?

Any History of any Other Gynecological Disorders?

Additional Information: