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OBSTETRICS AND GYNECOLOGY

Welcome to our practice! Please take a moment to fully complete this form to the best of your ability. This will begin to provide us with the necessary information to help us better understand your health care needs.

Date_____________ Name____ Age______

Date of Birth _______________ First day of Last Menstrual Period _______________________________

If postmenopausal, age at last period _____________________________

Are you sexually active: ______ With men, women, or both? ______

Preferred pronouns: _______________

What do you use for contraception (if applicable)? ______________________

Primary Care physician ____

Preferred pharmacy ____

I. Reason for today's visit ____

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

a. Any prior surgeries? ____

b. List any Hospitalization you have had ____

c. List all Medical Problems ____

d. List all Medications you are currently taking and dosages____

e. List all Medications to which you are Allergic ____

f. Have you ever had any Blood Transfusions ____

g. Genetic test results (if applicable) ____

III. Social History

a. Marital Status ____

b. What kind of work do you do?____

c. Do you smoke tobacco/marijuana/vape? ____

d. Do you drink alcohol? ______________ If yes, how many drinks per week? ______

e. Do you use any recreational/illicit substances? If so, what kind/how often? ____

V. Family History (Health of Mother, Father, Siblings)
In your family, is there a history of the following (Please include age at diagnosis):

a. Breast Cancer ______________________
b. Uterine Cancer ______________________
c. Ovarian Cancer ______________________
d. Colon Cancer ______________________
e. High Blood Pressure/ Heart Disease ______________________
f. Osteoporosis ______________________
g, Diabetes ______________________
h. DVT/ Blood Clot ______________________

VI. Review of Systems (Include dates, diagnoses, treatment)

a. Heart problems? ______________________
b. Lung problems? ______________________
c. Digestion problems? ______________________
d. Urination problems? ______________________
e. Endocrine problems? ______________________
f. Musculoskeletal problems? ______________________
g. Psychiatric problems? ______________________
h. Other probems? ______________________

VII. Obstetrical History (if applicable)

a. How many Term Deliveries (greater than 37 weeks)? ________ Premature deliveries (less than 37 weeks) ________
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. Have you had any Serious Complications with any Previous Pregnancies? ______________________

VIII. Gynecological History (Only complete A-F **if still getting periods)**

a. Age of your First Period? ________ How often are your periods? ________ Days of Flow? ________
b. Do you have Cramps? ________ Are they Severe? ______________________
c. Amount of Menstrual Flow: Heavy? ________ Average? ________ Light? ________
d. Do you have Premenstrual Water Retention or Mood Changes? ______________________
e. Do you ever have Irregular Menstrual Cycles? ______________________
f. Any History of Bleeding between Periods? ______________________
g. Any History of Bleeding after Intercourse? ______________________
h. Any History of Abnormal Pap Smears? If yes, dates and types of treatment (colpo/LEEP, etc)? ______________________
i. Any History of Excessive Vaginal Infections? ______________________
j. Any History of Painful Intercourse? ______________________
k. Any History of Breast Problems? ______________________
l. Any History of Sexual Problems? ______________________

IX. Any History of any Other Gynecological Disorder? ______________________