

**OB/GYN HEALTH PARTNERS
PATIENT MEDICAL HISTORY FORM**

Name _____ Date of Birth ____/____/____ Today's Date _____
 Single Married Separated Divorced Widowed Referred By _____
 Primary Care Physician _____

Medical History Have you ever had any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Clots in Lungs/Legs | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Drug or Alcohol Problem | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pelvic Infections | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic Condition |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

List any allergies to medications: _____ No Known Allergies

Surgical History Please list all surgeries with dates:

Obstetrical History/Adoption History

Check here if you have never been pregnant Check here if you have adopted children and list names below

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gyn History

Age of first period _____ Periods are: Regular Irregular Painful Not really bothersome
 Age of last period _____ Flow is: Light Light to moderate Moderate to heavy Very heavy
 Cycle length: every _____ days
 lasting _____ days

Are you sexually active? Yes No virginal Sexual preference: heterosexual homosexual bisexual
 New partners? yes no Number of lifetime partners _____

Method of Birth Control: condoms pills patch vaginal ring tubal/Essure IUD partner with vasectomy natural family planning Implanon none other

Have you ever had any of the following STDs? Chlamydia Gonorrhea Herpes HPV Syphilis Trichomonas HIV Hepatitis B Hepatitis C Never had any

Have you ever had any of the following? Fibrocystic breasts Ovarian cysts Endometriosis Uterine fibroids

Date of last pap smear _____ normal abnormal

Have you ever needed any of the following for an abnormal pap? Colposcopy Cryosurgery LEEP/Laser/Conization No

Date of last mammogram _____ Normal Abnormal Never had one
 Date of last bone density _____ Normal Osteopenia Osteoporosis Never had one
 Date of last colonoscopy _____ Never had one

Family History

Please list any close relatives with a history of the following:

Relative/Age at Diagnosis		Relative	
<input type="checkbox"/> Breast cancer		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Ovarian cancer		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Uterine cancer		<input type="checkbox"/> Heart Disease (heart attack,	
<input type="checkbox"/> Colon cancer		stroke, bypass surgery)	

Social History

- | | | | |
|-----------------|------------------------------|-----------------------------|---|
| Alcohol use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, _____ drink(s) per day/week/month |
| Tobacco use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, _____ pack(s) per day for _____ years |
| Street drug use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Type and frequency _____ |
| Exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Type and frequency _____ |
| Caffeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week |
| Sexual Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> yes <input type="checkbox"/> no Counseling? <input type="checkbox"/> yes <input type="checkbox"/> no |
| Physical Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> yes <input type="checkbox"/> no Counseling? <input type="checkbox"/> yes <input type="checkbox"/> no |
| Emotional Abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, are you safe now? <input type="checkbox"/> yes <input type="checkbox"/> no Counseling? <input type="checkbox"/> yes <input type="checkbox"/> no |

Review of Systems Do you currently have any of the following?

- | | <u>Comments</u> | | <u>Comments</u> |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Generally healthy | | <input type="checkbox"/> Y <input type="checkbox"/> N Frequent urination | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Recent weight gain or loss of 25 lbs. | | <input type="checkbox"/> Y <input type="checkbox"/> N Burning with urination | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever | | <input type="checkbox"/> Y <input type="checkbox"/> N Incontinence | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Vision problems (excluding glasses) | | <input type="checkbox"/> Y <input type="checkbox"/> N Urgency | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems | | <input type="checkbox"/> Y <input type="checkbox"/> N Bladder infection | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hearing loss | | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach pains | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chest pain | | <input type="checkbox"/> Y <input type="checkbox"/> N Vaginal discharge | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Varicose veins | | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular vaginal bleeding | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath | | <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic pain | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic cough | | <input type="checkbox"/> Y <input type="checkbox"/> N Painful intercourse | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea | | <input type="checkbox"/> Y <input type="checkbox"/> N Breast lumps | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Constipation | | <input type="checkbox"/> Y <input type="checkbox"/> N Back pain | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood in stools | | <input type="checkbox"/> Y <input type="checkbox"/> N Joint/muscle pain | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn/reflux | | <input type="checkbox"/> Y <input type="checkbox"/> N Depression/anxiety | |
| <input type="checkbox"/> None of the above | | <input type="checkbox"/> None of the above | |

Patient Signature _____ Date _____

Clinician Signature _____ Date _____

Annual Review #2 Clinician Signature _____ Date _____

Annual Review #3 Clinician Signature _____ Date _____