Women's OBGYN Care, PLLC
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PATIENT HISTORY FORM

Patient Name: _____, DOB:_____
Referred By Dr: _____, (Name of Clinic/Hospital):_____
Purpose of the visit: Well Woman Exam☐ Obstetric (Pregnancy related)☐ Gynecologic issues☐
Specify:_____

1.CURRENT MEDICATIONS

Name	Dose/Frequency	Reason

2. ALERGIES

Known Latex Allergy? ☐ No, ☐ Yes / Known Drug Allergies? ☐ No, ☐Yes if yes, please detail below,

Allergic to (Medication Name)	Type of Reaction

3. Medical History

Breast Conditions	☐Abnormal Mammogram	☐Breast cancer ☐Left ☐ Right	☐Breast Implants
	☐Fibrocystic Breasts		
Heart or Circulation Conditions Cardiovascular	☐Congenital Heart Disease	☐CVA (Stroke)	☐Mitral Valve Disorders (MVP)
	☐Congestive Heart Failure	☐Hypertension (High Blood Pressure)	☐Pulmonary Embolism (Blood clot in Lung)
	☐Coronary Artery Disease	☐Irregular Heart Beat	☐Thrombophlebitis (Blood clot in Extremity)
Endocrine (Glandular) Disorders	☐Diabetes- Type I (Insulin Department)	☐Pituitary Gland Disorder	☐High Cholesterol
	☐Diabetes- Type II	☐Thyroid Disease (Hypo) or (Hyper)	
Immune System Diseases	☐Chronic Fatigue Syndrome	☐HIV (Human Immunodeficiency Virus)	
Gastrointestinal (GI) Problems	☐Hepatitis A	☐Hepatitis B	☐Hepatitis C
	☐Colitis, Ulcerative	☐Crohn's Disease	☐Irritable Bowel Syndrome
Blood (Hematologic) Disorders	☐Anemia	☐Clotting disorder	
	☐Bleeding Disorder	☐Sickle cell Trait or Disease	

Patient Initial and Date:_____

Psychiatric or Emotional Conditions	☐ADHD/ADD	☐OCD (obsessive-compulsive)	☐Major depression
	☐Bipolar (Manic depressive)	☐Postpartum Depression	☐Severe anxiety or panic attacks
Respiratory (Lung) or ENT Disorders	☐Asthma	☐Tubersulosis	
	☐COPD	☐Pneumonia- recurrent	☐Cystic Fibrosis
	☐Lung cancer	☐Sleep Apnea	
Skin Conditions	☐Acne (Severe)	☐MRSA	☐Hirsutism (Excess Hair Growth)
	☐Eczema	☐Psoriasis	
Musculoskeletal Disorders	☐Arthritis	☐Fibromyalgia	☐Scoliosis
	☐Arthritis, Rheumatoid	☐Osteopenia	☐Systemic Lupus Erythematosus
	☐Joint Pain	☐Osteoporosis	
Neurologic Disorders	☐Common Migraines	☐Multiple Sclerosis	☐TIA or Stroke
	☐Headaches (Other)	☐Seizure Disorders (Epilepsy)	
Urinary (Urological) Disorders	☐Calculus (Kidney Stones)	☐Stress Incontinence	☐Urinary Tract Infections (UTI)
	☐Psylonephritis	☐Urge Incontinency/Overactive Bladder	
Genetic Disorders, Specify			
Others, Please Specify			

4. Menstrual History (complete even if post-menopausal or no longer having periods)

1. Age at first period: _____ years
2. If your menstrual periods are regular; periods start every:_____ days
3. If your menstrual periods are irregular; periods start every: _____ to _____ days (e.g. 12 to 60)
4. Duration of bleeding: _____ days
5. Does bleeding or spotting occur between periods? ☐Yes, ☐ NO
6. Does bleeding or spotting occur after intercourse? ☐Yes, ☐ NO
7. First day of last menstrual period (LMP)_____.
8. Is pain associated with periods? ☐Yes, ☐ NO, ☐ Occasionally ; If Yes than Is it before menses? ☐, During menses? ☐, Both? ☐
9. Are you taking any pain medications? ☐Yes, ☐ NO Specify_____

5. GYNECOLOGICAL DISEASE HISTORY **Tick (√)** any that applies

☐Venereal warts	☐Dysmenorrhea (Painful Menses)	☐Human Papilloma Virus Infection (HPV)
☐Herpes-genital	☐Endometrial (Uterine) Cancer	☐Ovarian Cancer
☐Chlamydia	☐Endometriosis	☐Ovarian cysts
☐Abnormal pap smear	☐Fibroids	☐Pelvic Inflammatory Disease (PID)
☐Cervical cancer (Neoplasm	☐Herpes	☐Polycystic Ovarian Syndrome (PCOS)
☐Trichomonas	☐Sexually Transmitted Disease (STD)	☐Vulvar cancer (Neoplasm)
☐Gonorrhea	☐Vaginal Cancer (Neoplasm)	☐Vaginal Infections

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6. BIRTH CONTROL HISTORY

What birth control method(s) do you currently use?

_____, ☐ Sometimes, ☐ All the time

When last time taken/Inserted? _____

7. SEXUAL HISTORY

1. Are you currently sexually active? NO☐ Yes☐ (Male ☐, Female ☐)
2. Current partner since how long? _____ Months/Years
3. Age at first sexual activity started? _____
4. Number of sexual partners in lifetime _____
5. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ NO☐

8. PAP SMEAR/MAMMOGRAM/DEXA/COLONOSCOPY/IMMUNIZATION HISTORY

1. Date of last pap smear:_____ Date of last Mammogram: _____
2. Date of Last Dexa Scan:_____ Date of last Colonoscopy: _____
3. Have you had abnormal pap smears/mammogram? ☐Yes, ☐ NO Type of Abnormality_____
4. Have you had treatment for abnormal smears? ☐Yes, ☐ NO
5. If yes, what type(s) of treatment have you had?
   - Repeat PAP ☐Yes, ☐ NO Year_____
   - Cryotherapy ☐Yes, ☐ NO Year_____
   - Laser ☐Yes, ☐ NO Year_____
   - Cone biopsy ☐Yes, ☐ NO Year_____
   - Loop excision (LEEP) ☐Yes, ☐ NO Year_____
   - Colposcopy ☐Yes, ☐ NO Year_____
6. Immunizations:
   TETANUS? _____PNEUMONIA? _____FLU?_____HEPATITIS B SERIES?_____
   HPV? _____ Meningitis?_____ Other_____

9. OBSTETRICAL HISTORY INCLUDING ABORTIONS AND ECTOPIC (TUBAL) PREGNANCIES:

Child's DOB	Place/ Physician or Abortion	Duration of Pregnancy	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	Child Sex/Name	Child Birth Weight	Child Present Health

10.PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES, Tick (√) any that apply

SURGERY	(√)	YEAR	SURGERY	(√)	YEAR
D & C	☐		Ovarian surgery	☐	
Hysteroscopy	☐		L cyst(s) removed ovarian	☐	
Infertility surgery	☐		R cyst(s) removed ovarian	☐	
Tuboplasty	☐		L ovary removed	☐	
Tubal ligation	☐		R ovary removed	☐	
Laparoscopy	☐		Vaginal or bladder repair for prolapsed or incontinence	☐	
Hysterectomy (Vaginal)	☐		Cesarean section	☐	
Hysterectomy (abdominal)	☐		Other (specify)	☐	
Myomectomy (Fibroid Removal)	☐				

Patient Initial and Date:_____

11. FAMILY MEDICAL HISTORY

Members	Alive	Deceased	Unknown	Year of Birth (e.g. 2005)	Age in Years (e.g. 25)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
	(Status)											
Father	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Paternal Grand Father	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Paternal Grand Mother	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Maternal Grand Father	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐			☐	☐	☐	☐	☐	☐	☐
Siblings	☐ Brothers		☐ Sisters		☐ Healthy		**Note:**					
Children	☐ Sons		☐ Daughters		☐ Healthy							

12.SOCIAL HISTORY

Marital Status: ☐ Single, ☐ Married, ☐ Widowed, ☐ Divorced, ☐ Not answered

1. Alcohol use:

Did you have a drink containing alcohol in the past year? ☐ Yes, ☐ NO, If YES;

How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 points)
☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point) ☐ 3 or 4 drinks (1 point) ☐ 5 or 6 drinks (2 points)
☐ 7 or 9 drinks (3 points) ☐ 10 or more drinks (4 points)

How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point) ☐ Less than monthly (1 point) ☐ Monthly (2 points)
☐ Weekly (3 points) ☐ Daily or almost daily (4 points)

Interpretation: ☐ **Positive,** ☐ **Negative**

Illegal Drug Use: ☐ Yes, ☐ NO Which Drug (s)_____ How often:_____

2. Tobacco Use: ☐ Yes, ☐ NO

Are you a, ☐ Current smoker, ☐ Former smoker, ☐ Non-smoker, If Current Smoker?

How often do you smoke cigarettes? ☐ Every day, ☐ Some days, but not every day

How many cigarettes a day do you smoke?

☐ 5 or less, ☐ 6-10, ☐ 11-20, ☐ 21-30, ☐ 31 or more

How soon after you wake up do you smoke your first cigarette?

☐ Within 5 minutes, ☐ 6 to 30 minutes ☐ 31- 60 minutes, ☐ After 60 minutes

Are you interested in quitting?

☐ Yes, ☐ NO, ☐ Thinking to Quit

Exercise Habits:

☐ Yes, ☐ NO, If yes What:_____How Often:_____

Occupation: _____

Patient Initial and Date:_____

13.REVIEW OF SYSTEMS/	Tick (√) any problems that you are CURRENTLY having		
CONSTITUTIONAL	☐Weight loss	☐Fever	☐Change in height
	☐Weight gain	☐Fatigue	
EYES	☐Double vision	☐Spots before your eyes	☐Vision changes
	☐Glasses/contacts		
EAR, NOSE,THROAT	☐Earaches	☐Ringing in ears	☐Hearing problems
	☐Sore throat	☐Mouth sores	☐Dental problems
CARDIOVASCULAR	☐Painful breathing	☐Chest pain or pressure	☐Difficulty breathing on exertion
	☐Swelling of legs	☐Rapid or irregular heartbeat	
RESPIRATORY	☐Wheezing	☐Coughing up blood	☐Short of breath
	☐Chronic cough		
GASTROINTESTINAL	☐Frequent diarrhea	☐Bloody stool	☐Nausea
	☐Vomiting	☐Indigestion	☐Constipation
	☐Involuntary loss of gas/stool		
URINARY TRACT	☐Blood in urine	☐Pain with urination	☐Strong urgency to urinate
	☐Frequently	☐Involuntary unintended loss of urine	☐Urine loss when coughing or lifting
GYNECOLOGIC	☐Abnormal bleeding	☐Painful periods	☐Premenstrual syndrome/PMS
	☐Painful intercourse	☐Fibroids	☐Endometriosis
	☐Infertility	☐Abnormal vaginal discharge	
SKIN	☐Rash (persistent)	☐Sores	☐Dry
	☐Skin	☐Moles (changes in color or shape)	
BREASTS	☐Pain in breast	☐Nipple discharge	☐Lumps
NEUROLOGIC	☐Dizziness	☐Seizures	☐Numbness
	☐Trouble walking	☐Severe memory problems	☐Frequent or severe headaches
PSYCHIATRIC	☐Depression	☐Severe anxiety	☐Severe sleep difficulties
ENDOCRINE	☐Hair loss	☐Heat/cold intolerance	☐Abnormal thirst
	☐Hot flashes		
HEMATOLOGIC/ LYMPHATIC	☐Frequent bruises	☐Cuts that do not stop bleeding	☐Enlarged lymph nodes (glands)
MUSCULOSKELETAL	☐Muscle pain	☐Joint pain	

☐ I have marked all applicable medical conditions above;
☐ I do not have any medical conditions mentioned above.

I attest that the information here is true and correct to the best of my belief.

_____ _____

Patient's/Guardian Signature DATE