Account #: _____ Date: _____

obgyn specialists

Patient Medical History Form

Name: _____ Preferred Name: _____ DOB: _____ Age: _____

Primary Care MD/Clinic: _____ Referring MD: _____

Medication Allergies/Reactions: _____ ☐ None ☐ Eggs ☐ Latex ☐ Iodine

Current Contraception (including tubal ligation, vasectomy, condoms, etc) _____

Date of last annual exam: _____ First day of last menstrual period: _____

What symptoms and concerns do you want to discuss? _____

_____

Have you seen another provider for the same condition? ☐ No ☐ Yes, who/where? _____

Pap Smear: Please list date of last pap smear_____ ☐ Normal ☐ Abnormal
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
Date/Treatment: _____

Mammogram: Please list date of last mammogram_____ ☐ Normal ☐ Abnormal
☐ Never

Colonoscopy: Please list date of last colonoscopy_____ ☐ Normal ☐ Abnormal
☐ Never

Bone Density: Please list date of last bone density_____ ☐ Normal ☐ Abnormal
☐ Never

Current Medications (please include vitamins, herbal supplements, and over the counter medications)

Medication/Strength	Dosage	Prescribing MD/NP/PA

Obstetrical History

Have you had any miscarriages? ☐ No ☐ Yes, when? _____ Have you had any terminations? ☐ No ☐ Yes, when?_____

Date Child's Sex/Name Birth Weight Labor Length Vaginal/Cesarean MD/Hospital Complications

_____

_____

_____

_____

Menstrual History

Age at Onset (your first period): _____ Frequency: _____ Days of Flow: _____

☐ Heavy Flow ☐ Bleeding Between Periods ☐ Bleeding After Intercourse ☐ Menstrual Cramping ☐ PMS

Menopause (age): Surgical Menopause (date):

Surgery and Hospitalization History (including C-sections) ☐ No changes since last completed form

Date Surgery MD/Hospital Complications

_____

_____

_____

_____

Gynecological History

Are you sexually active? ☐ Yes ☐ No Do you have multiple sexual partners? ☐ Yes ☐ No

Partners in Last Year_____ # Lifetime Partners_____ Is/Are your partner(s) ☐ Male ☐ Female ☐ Both

Does anything listed apply to you:

Urine: ☐ Frequency ☐ Urgency ☐ Burning ☐ Incontinence ☐ Pain

Vagina: ☐ Dryness ☐ Itching ☐ Discharge ☐ Painful Intercourse

Menopause: ☐ Hot Flashes ☐ Night Sweats ☐ Bleeding ☐ Other_____

Other: ☐ AIDS/HIV ☐ Chlamydia/Gonorrhea ☐ Genital Warts ☐ Herpes

Social History

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Are you employed? ☐ No ☐ Yes Where:_____Position:_____

Is anyone physically, sexually, or emotionally hurting you? ☐ No ☐ Yes Who?_____

Do you wear seat belts? ☐ Yes ☐ No

Do you have carbon monoxide indicators in your home? ☐ Yes ☐ No

Do you have smoke detectors in your home? ☐ Yes ☐ No

Do you use tobacco/e-cig? ☐ No ☐ Yes, Amount_____ Drink alcohol? ☐ No ☐ Yes, Amount_____

Do you use street drugs? ☐ No ☐ Yes, type/quantity/frequency? _____

Exercise: ☐ None / Routine of:_____

Special diet: ☐ None ☐ Weight Loss ☐ Low Fat ☐ Vegan ☐ Gluten Free ☐ Diabetic ☐ Vegetarian ☐ Low Carb

Do you drink caffeinated beverages? ☐ No ☐ Yes Quantity/Frequency:_____

Current Review of Systems (please check if you are now or recently have experienced any of the following)

Constitutional: ☐ Anorexia/Bulimia ☐ Weight Loss ☐ Weight Gain ☐ Fatigue ☐ Sweating

Eyes: ☐ Double Vision ☐ Spots ☐ Vision Loss

Ear/Nose/Throat: ☐ Ringing in Ear ☐ Earache ☐ Sore Throat ☐ Bleeding Gums ☐ Congestion

Cardiac: ☐ Chest Pain ☐ Palpitations ☐ Swelling/Edema (location):_____

Respiratory: ☐ Wheezing ☐ Cough ☐ Shortness of Breath

GI: ☐ Constipation ☐ Diarrhea ☐ Bloating ☐ Black or Bloody Stools

Muscle: ☐ Joint Pain ☐ Muscle Cramps ☐ Weakness

Skin: ☐ Rash ☐ Dryness ☐ Lesions ☐ Acne ☐ Moles

Breast: ☐ Lump ☐ Fibrocystic ☐ Discharge ☐ Skin Changes ☐ Pain

Neuro: ☐ Headaches ☐ Tremors ☐ Weakness ☐ Seizures

Psych: ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Memory Loss ☐ Moodiness

Endo: ☐ Excess Thirst ☐ Hair Loss ☐ Hair Growth ☐ Cold/Heat Intolerance ☐ Excess Urination

Lymph: ☐ Bruising ☐ Nosebleeds ☐ Swollen Glands

Past Illnesses:

Have you experienced any of the following?

☐ AIDS/HIV ☐ Asthma ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Heart Disease ☐ Ulcers

☐ Thyroid Problems ☐ Phlebitis ☐ Seizures ☐ Arthritis ☐ Diverticulitis ☐ Kidney Infection

☐ Gonorrhea/Chlamydia ☐ Herpes ☐ Genital Warts

Personal/Family History ☐ No changes since last completed form

Please include yourself, immediate family, grandparents, aunts and uncles

	Self	Family	Relationship	Age Diagnosed
Breast Cancer	☐	☐		
Ovarian Cancer	☐	☐		
Endometrial Cancer	☐	☐		
Colon Cancer	☐	☐		
Colon Polyps	☐	☐		
Ulcerative Colitis	☐	☐		
Other Cancers (list type)	☐	☐		
High Blood Pressure	☐	☐		
Heart Disease/Angina	☐	☐		
Elevated Cholesterol	☐	☐		
Osteoporosis/Arthritis	☐	☐		
Broken Hip/Spine	☐	☐		
Diabetes	☐	☐		
Kidney Disease	☐	☐		
Mental Illness	☐	☐		
Substance Abuse	☐	☐		
Blood Clots/Thrombosis	☐	☐		
Problems with Anesthesia	☐	☐		
Thyroid Problems	☐	☐		
Other	☐	☐		

Vaccinations (have you had or have you been immunized against the following – include dates if possible)

☐ No changes since last completed form

☐ MMR_____ ☐ Pneumonia _____ ☐ Shingles _____ ☐ Polio _____ ☐ Tetanus/Diphtheria/Pertussis _____

☐ Chicken Pox _____ ☐ HPV (Gardasil) _____ ☐ Hepatitis A Series _____ ☐ Hepatitis B Series _____

Have you had a TB test (mantoux)? ☐ No ☐ Yes Year: _____ Result: _____

Do you have specific requests for:

☐ New Medication: _____ ☐ Tests: _____

☐ Refills: _____ ☐ Completion of forms: _____

☐ Vaccinations: _____ ☐ School or work release: _____

☐ Referrals: _____ ☐ Other: _____

Patient Signature: _____ **Date:** _____

Thank you for taking the time to complete your medical history!