

Patient Name: _____

Today's Date: _____

OBHx G ____ P ____ Last First MI

If no pregnancies, by choice? Yes No

Pregnancy History (starting with first pregnancy; please include abortions, spontaneous or elective)

| Baby's DOB | Wks @ birth Newborn wt | Type of DEL Hrs in labor | Pain meds? | DELIVERED BY | COMPLICATIONS | NEWBORN SEX & NAME |
|------------|------------------------|--------------------------|------------|--------------|---------------|--------------------|
| | | | | | | F / M |
| | | | | | | F / M |
| | | | | | | F / M |
| | | | | | | F / M |
| | | | | | | F / M |
| | | | | | | F / M |
| | | | | | | F / M |

GYNHx

Birth Control: _____

Menstrual History: Age at first period _____ y/o

Last menstrual period: _____

Period length _____ to _____ days

Cycle (from the start of one period to the next):

Regular Irregular

lasting from _____ to _____ days

Problems: Period pain: _____

Pain with sex: _____

Other: _____

Sexual History (High Risk)

partners, last 5 yrs _____

Practice "safe sex" Yes _____

No _____

Tattoo Hx: None

STD chk after tattoo (esp Hep C)? Yes No

STD History

Trichomonas Hepatitis B / C

Chlamydia Herpes Virus

Gonorrhea HIV / AIDS

Syphilis HPV

Last STD check: _____

Pap History

Last pap (MMM yyyy) _____

Nml Abn _____

Abnormal paps Never Yes _____

Abnormal paps (cont):

Treatment: None

Cryotherapy LEEP

Cone Biopsy LASER

Follow-up pap (MMM yyyy) _____

Nml Abn _____

Breast / Mammogram History

Self Breast Exams? _____

Breast Problems _____

Date of last mammogram _____

Where done _____

Nml Abn _____

Follow-up? _____

Safety Hx: Do you feel safe @ home? Yes

No _____

Menopause History

Age at menopause _____ y/o

Hormone replacement? No _____

Yes Type(s) _____

Mom's Menopause history: _____

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GENERAL MEDICAL Hx

General

- Previous Physical Exam (date) _____
- Chills
- Depression / Nervousness
- Fever
- Forgetfulness
- Loss of Sleep
- Sweats
- Weight change

Infectious Diseases

- Rheumatic / Scarlet fever
- Scarlet fever
- Pneumonia
- Tuberculosis
- Other

Muscle/Joint/Bone (pain, weakness, numbness)

- Swelling / stiffness
- Night cramps
- Neck / Shoulders
- Arms / Hands
- Back / Hips
- Legs / Feet
- Joints: _____

Glandular

- Diabetes
- Thyroid disease
- Other

Cardiovascular

- Anemia
- Chest pain
- Leg pain / Poor circulation
- High blood pressure
- Irregular / Rapid heart beat
- Swelling of ankles
- Varicose veins
- Bleeding problems
- Blood clots

Gastrointestinal

- Appetite poor / excessive
- Bloating
- Bowel changes
- Constipation / Diarrhea
- Jaundice
- Gas
- Hemorrhoids
- Indigestion
- Nausea / Vomiting
- Rectal Bleeding

Head

- Seizure / Convulsions
- Headaches
- Dizziness / Passing out

Eye, Ear, Nose, Throat

- Hay Fever
- Hoarseness
- Loss of hearing
- Difficulty swallowing
- Visual problems

Lungs

- Asthma
- Short of breath
- Pain

Kidney/Bladder

- Infections
- Stones
- Blood in urine
- Trouble with urination
- Losing urine
- Going too often

Skin

- Change in moles
- Scars
- Sore that won't heal

| Past Medical History | |
|----------------------|----------------|
| Year | Illness/Injury |
| | |
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| Past Surgical History | |
|-----------------------|---------|
| Year | Surgery |
| | |
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| | |

Patient Name: _____
Last First MI

Today's Date: _____

Explain Reason for Initial Appointment: _____

| | |
|---|-------------------|
| ALLERGIES <input type="checkbox"/> No known drug allergies | |
| Drug | Allergic Reaction |
| | |
| | |
| | |

| | | |
|--|-------------|---------------------------|
| SUBSTANCE USE <input type="checkbox"/> None | | |
| Drug | Quit (year) | Use History |
| Tobacco | | ____ packs/d x ____ years |
| Alcohol | | ____ drinks per ____ |
| Illicit drug(s) | | |

Exercise Habits: None Yes _____

| | | | | | |
|---|--------|---------------|------------|--------|---------------|
| Present Medications: <input type="checkbox"/> Alt Meds: | | | | | |
| Name of Rx | mg/tab | Times per day | Name of Rx | mg/tab | Times per day |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | |
|------------------------|-------------------|--------------------------------------|
| Family History: | | |
| Relation | Present Age (yrs) | If died, age at, and cause of, death |
| Father | | |
| Mother | | |
| Brother(s) | | |
| | | |
| Sister(s) | | |
| | | |
| Others | | |

| | | |
|--|---|-----------|
| Check if you/relative (<input type="checkbox"/>/ <input type="checkbox"/>) have had any of the following: | | |
| MEDICAL PROBLEM: | You Relative | DESCRIBE: |
| Birth Defect | <input type="checkbox"/> / <input type="checkbox"/> | |
| Asthma, Hay Fever | <input type="checkbox"/> / <input type="checkbox"/> | |
| Breast Cancer | <input type="checkbox"/> / <input type="checkbox"/> | |
| Pelvic Organ Cancer (type ?) | <input type="checkbox"/> / <input type="checkbox"/> | |
| Other Cancer(s) | <input type="checkbox"/> / <input type="checkbox"/> | |
| Bleeding/Bruising Problem | <input type="checkbox"/> / <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> / <input type="checkbox"/> | |
| Heart Attack/Stroke | <input type="checkbox"/> / <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> / <input type="checkbox"/> | |
| Kidney Disease | <input type="checkbox"/> / <input type="checkbox"/> | |
| Tuberculosis | <input type="checkbox"/> / <input type="checkbox"/> | |
| Intestinal Problems | <input type="checkbox"/> / <input type="checkbox"/> | |
| Blood Transfusions | <input type="checkbox"/> / <input type="checkbox"/> | |
| Osteoporosis | <input type="checkbox"/> / <input type="checkbox"/> | |
| Other: | <input type="checkbox"/> / <input type="checkbox"/> | |
| Other: | <input type="checkbox"/> / <input type="checkbox"/> | |