

OBGYN West Health History Form

Please fill in all information on front and back of form

Office Patient ID # _____

Today's Date _____

Name _____ Date of Birth ____/____/____

Referred by _____ Primary Care Doctor _____

Reason for today's visit _____

Menstrual History

First day of last period ____/____/____ Age at first period _____

Your periods occur every _____ days and last for _____ days

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy flow ☐ Clots ☐ Pain/Cramping ☐ Irregular periods ☐ Discharge

☐ Bleeding between periods ☐ Other _____

If menopausal

Age/year began _____ Any Postmenopausal bleeding? ☐ No ☐ Yes

Contraceptive History

Are you currently sexually active? ☐ Yes ☐ No ☐ Never been

How many life time partners? _____ How many in the last year? _____

Current method of birth control (include tubal or vasectomy) _____

Any problems with current method? ☐ No ☐ Yes _____

Previously used methods (Check all that apply)

☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ Depo Provera ☐ IUD

☐ NuvaRing ☐ Implanon ☐ Nexplanon ☐ Spermicide ☐ Sponge ☐ Other _____

☐ No previous birth control

Gynecological History

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear

☐ Breast Pain

☐ Chronic Pelvic Pain

☐ DES Exposure

☐ Endometriosis

☐ Genital Warts

☐ Infertility

☐ Ovarian Cysts

☐ Pain with Intercourse

☐ PID

☐ PMS

☐ Recurrent Miscarriage

☐ Recurrent Vaginitis

☐ STD _____

☐ Urinary Incontinence

☐ UTI (chronic)

☐ Uterine Fibroids

☐ None of the above

(additional medical history on the back of form)

Preventive Care History

Last Pap Smear Date: _____ ☐ Normal ☐ Abnormal

Last Mammogram Date: _____ ☐ Normal ☐ Abnormal

Last Colonoscopy Date: _____ ☐ Normal ☐ Abnormal

Last DEXA (Bone Scan) Date: _____ ☐ Normal ☐ Abnormal

Last Cholesterol Test Date: _____ ☐ Normal ☐ Abnormal

Vaccinations (year) Gardasil _____ Flu _____

Herpes Zoster (Shingles) _____ TDAP (Tetanus) _____

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age in Wks @ Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Surgical History (Please list all surgical procedures) ☐ None

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Surgery _____ Date _____

Current Medication History

(Please include current prescriptions and medications ONLY) ☐ None

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Allergy History (List all medication allergies and reaction) ☐ None

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Social & Lifestyle History

Marital Status _____ Occupation _____

Tobacco Smoker ☐ Never ☐ Former ☐ Current - Amt/Day _____

Alcohol Use ☐ No ☐ Yes If yes, Amt/Wk _____

Caffeine Use ☐ No ☐ Yes Street Drugs/Marijuana use ☐ No ☐ Yes

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Regular Exercise ☐ No ☐ Yes Type _____ Amt/Wk _____

Monthly Breast Exam ☐ No ☐ Yes Have you had Chicken Pox ☐ No ☐ Yes

Do you have a Health Care Directive (living will) ☐ No ☐ Yes

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