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OB/GYN
PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth____/____/____ Today's Date_____
[Single [Married [Separated [Divorced [Widowed Referred By_____

Medical History Have you ever had any of the following?

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

☐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 _____
Age of last period _____
Cycle length: every _____ days
lasting _____ days

Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Not really bothersome

Flow is: ❑ Light ❑ Light to moderate ❑ Moderate to heavy ❑ Very heavy

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 ❑ other ❑ none

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