OB/GYN HISTORY FORM

COMPLETE BOTH SIDES

Name:	(label)
Weight: **Height:**	
Reason for Visit:	

(Do not write in this space)

Past Medical History

Diabetes □ Yes □ No	**Thyroid Problems** □ Yes □ No	**Gastrointestinal** □ Yes □ No
Comments:	Comments:	Comments:
High Blood Pressure □ Yes □ No	**Urinary Tract Infections** □ Yes □ No	**Neurological/Epilepsy** □ Yes □ No
Comments:	Comments:	Comments:
Heart Disease □ Yes □ No	**Blood Clots Leg/Lung** □ Yes □ No	**Hepatitis/Liver Disease** □ Yes □ No
Comments:	Comments:	Comments:
Kidney Disease □ Yes □ No	**Asthma** □ Yes □ No	**Psyciatric** □ Yes □ No
Comments:	Comments:	Comments:
Surgeries (Reason & Year)	**Other Medical Problems**	**Hospitalizations (Reason & Year)**
1	1	1
2	2	2
3	3	3
4	4	4

Past Gynecologic History

Last Menstrual Period:	**Sexually Active?** ☐ Yes ☐ No
Duration of Flow (Days): □ Light □ Moderate □ Heavy	**Your partner Is** □ Male □ Female □ Both
Cramps? □ None □ Mild □ Mod □ Severe	**Clots:** ☐ Yes □ No
Time Between Periods:	**Contraception:**
Last Mammogram:	
Last Pap Smear	**History of Abnormal Pap?**
Please check if you have or previously had the following:	
Sexually Transmitted Disease: □ Herpes □ Gonorrhea □ Chlamydia □ HPV □ Syphilis □ HIV	
☐ **Incontinence/Leakage of Urine**	**Prolapse:** □ Bladder □ Rectum □ Uterus
Comments:	

(continue on second page)

Past Obstetrical History

To include ALL vaginal births, C-Sections, miscarriages, ectopics, and abortions.

	1	2	3	4	5	6	7
Date: (Month/Year)							
Birth Weight							
Type of Delivery (Vaginal/C-Sect)							
Complications							

Medications and Dosage (Include Vitamins/Herbs)

Allergies (List Reaction)

Social History

Occupation:		**Marital Status:** □ Single □ Married □ Divorced		**Social Drug Use:** Amount:	□ Yes □ No How Often:
Cigarettes: For how long?	□ Yes	□ No	Pack/Day: Quit Date:	**Spouse's Name/Age/Occupation:**	
Alcohol Amount	□ Yes	□ No	Type: How Often:		

Family History

Breast Cancer Who:	□ Yes	□ No		**High Blood Pressure** Who:	□ Yes □ No
Ovarian Cancer Who:	□ Yes	□ No		**Heart Disease** Who:	□ Yes □ No
Uterine Cancer Who:	□ Yes	□ No		**Diabetes** Who:	□ Yes □ No
Colon Cancer Who:	□ Yes	□ No		**Psychiatric Disorder** Who:	□ Yes □ No
Osteoporosis Who:	□ Yes	□ No		**Gynecological Problem** Who:	□ Yes □ No

Exam/Plan