ASSOCIATES IN
Obstetrics & Gynecology

HISTORY FORM

PLEASE COMPLETE

Name:_____ Age:_____ Date:_____

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

Current Medications you are taking: ☐ None

_____.
_____.
_____.

Allergies: ☐ None _____.
_____.
_____.
_____.

HISTORY OF PRESENT ILLNESS: ☐ New Problem ☐ Existing Problem (check all that apply)

- ☐ Excessive menstrual flow
- ☐ Pelvic pain or pressure feeling
- ☐ Bladder trouble, burning, frequency, blood in urine, control problems
- ☐ Bowel problems, bleeding, hemorrhoids, severe constipation
- ☐ Hot flashes or suspected menopausal symptoms
- ☐ Unusual vaginal discharge, itching or burning
- ☐ Spotting or bleeding between periods
- ☐ Other

GYNECOLOGICAL HISTORY:

Date of Last Menstrual Period:_____ Length of period in days:_____ # of days between cycles:_____.

Has there been any change in your menstrual cycle in the last six months? ☐ Yes ☐ No

Explain:_____.

Last Pap:__/__/__ ☐ Normal ☐ Abnormal ☐ Previous history abnormal. Dexa Scan:__/__/__.

Last Mammogram:__/__/__ ☐ Normal ☐ Abnormal ☐ Previous history abnormal. Colonoscopy:__/__/__.

REPRODUCTIVE HISTORY:

No. Miscarriages:____

No. Pregnancies:____ No. Deliveries:____ No. Preterm Deliveries:____ No. Terminations:____ No. Living:____.

Labor/Delivery Complications: ☐ Yes ☐ No Explain_____.

Contraception? ☐ Yes ☐ No Type:_____ ☐ Present ☐ Past ☐ Vasectomy ☐ Tubal Ligation

SEXUAL HISTORY:

Sexually Active: ☐ Yes ☐ No Age at 1st Intercourse:_____.

Length with current partner:_____. Total Lifetime Partners:_____.

PAST HISTORY: ☐ **No Interval Change Since:**__/__/__

Surgeries:_____.

Medical History/Health History:_____.

Immunizations:_____. ☐ Gardasil

FAMILY HISTORY: ☐ **No Interval Change Since:**__/__/__

Mother: ☐ Living ☐ Deceased, Cause_____ Father: ☐ Living ☐ Deceased, Cause_____.

Sibling: Number Living_____ Number deceased_____ Cause(s)_____.

☐ Diabetes_____ ☐ High Blood Pressure_____ ☐ High Cholesterol_____.
☐ Heart Disease_____ ☐ Breast Cancer_____ ☐ Colon Cancer_____.
☐ Ovarian Cancer_____ ☐ Uterine Cancer_____ ☐ Other_____.

SOCIAL HISTORY:

Tobacco Use: ☐ Yes ☐ No_____. Seat Belt use: ☐ Yes ☐ No_____.
Alcohol: ☐ Yes ☐ No_____. Regular Exercise: ☐ Yes ☐ No_____.
Drug Use: ☐ Yes ☐ No_____. Domestic Violence: ☐ Yes ☐ No_____.

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Number of Children living in the home_____. Number of people in household_____.

Current or most recent job_____.

Do you have any emotional or sexual problems to discuss confidentially with the doctor? ☐ Yes ☐ No

(OVER)

Review Of Systems **HISTORY INTAKE FORM**

SIDE 2

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, OR OFTEN

	CURRENTLY	PAST	EXPLAIN
1. **CONSTITUTIONAL** Weight loss, or gain, fever or fatigue	☐	☐	
2. **EYES** Double Vision, spots before eyes, or vision changes	☐	☐	
3. **ENT/MOUTH** Ear aches, ringing in ears, sinus problems, sore throat, mouth sores, or dental problems	☐	☐	
4. **CARDIOVASCULAR** Painful breathing, chest pain, difficult breathing on exertion, swelling of legs, or palpitations of heart	☐	☐	
5. **RESPIRATORY** Wheezing, spitting up blood, shortness of breath, chronic cough	☐	☐	
6. **GASTROINTESTINAL** Diarrhea, bloody stool, or constipation. Nausea/vomiting	☐	☐	
7. **GENITOURINARY** Blood in urine, urgency, frequency, Pain with urination, incomplete emptying, or stress incontinence.	☐	☐	
Abnormal periods, or painful intercourse	☐	☐	
8. **MUSCULOSKELETAL** Muscle weakness	☐	☐	
9. **SKIN/BREAST** Pain in breast, discharge, Masses, rash or ulcers	☐	☐	
10. **NEUROLOGICAL** Dizziness, seizures, numbness, trouble walking	☐	☐	
11. **PSYCHIATRIC** Depression or frequent crying	☐	☐	
12. **ENDOCRINE** Dry skin, abnormal thirst or hot flashes	☐	☐	
13. **HEMATOLOGIC/LYMPHATIC** Frequent bruises, cuts that do not stop bleeding, or enlarged lymph nodes	☐	☐	
14. **ALLERGIC/IMMUNOLOGIC** Allergies (list)	☐	☐	

NO COMPLAINTS ☐

Patient Signature _____ **Date** _____