All About Women
OBSTETRICS & GYNECOLOGY

Medical History Form

Patient Name: _____ DOB: _____

Gynecologic History

What was the first day of your last period?	Are you currently sexually active? Yes / No If no, have you ever had sex? Yes / No
At what age did your periods start?	Any abnormal vaginal discharge? Yes / No
How often do you have a period? Every _____ days	Have you ever been treated for a pelvic infection? Yes / No
How many days does your period last? _____ days	Any pain with sex? Yes / No
Any pain with your periods? Yes / No	Have you ever been treated for infertility? Yes / No
Any changes in your periods? Yes / No	Have you ever had herpes? Yes / No
When was your last pap test?	Your present method of birth control is _____
Have you ever had an abnormal pap? Yes / No If yes, when…… If yes, explain……	Are you trying to get pregnant? Yes / No

Obstetrical History

	Number		Number		Number
Total Pregnancies		Abortions		Miscarriages	
Preterm Births (<37 wks)		Term Births		Living Children	

No.	Birth Date	Weight	Baby's Sex	Gestational Age @ Delivery	Vaginal or C-Section	Complications
1						
2						
3						
4						
5						
6						

Any history of diabetes, high blood pressure or pre-eclampsia with your pregnancies?
Any history of depression?
History of chicken pox or chicken pox vaccination?
History of rheumatic fever or heart disease?

Medical History

Are you allergic to any medications? Yes / No

If so, please provide name and list reaction...

Any History of…….

Asthma	Yes / No	Heart Failure	Yes / No
Diabetes	Yes / No	Heart Attack	Yes / No
Eating Disorder	Yes / No	High Blood Pressure	Yes / No
Bowel Problems	Yes / No	Abnormal Heart Rhythm	Yes / No
Ulcer or Gastritis	Yes / No	Blood Clots	Yes / No
Liver Problems	Yes / No	Lupus	Yes / No
Thyroid Problems	Yes / No	Sexually Transmitted Disease	Yes / No
Blood Problems	Yes / No	Cancer	Yes / No
Kidney Problems	Yes / No	If so, where?	

Serious Illness? If yes, explain…
Hospitalization? If yes, explain…
Blood Transfusion? If yes, explain…
Surgeries? If yes, list along with date…
Recent Immunizations: Hepatitis B? Tetanus?

Social History

Marital Status: ____ Single ____ Married ____ Partner ____ Widowed ____ Divorced

Tobacco: ____ Never smoked ____ Quit
____ Smoker (____ years smoked, ____ packs per day)

Alcohol: ____ Never ____ <1 week ____ 1-5 per week ____ Other

Drug Use: ____ Yes ____ No

Seat belt use: ____ Yes ____ No

Regular exercise: ____ Yes ____ No

Do you take calcium or dairy products: ____ Yes ____ No

Have you been hurt by anyone: ____ Yes ____ No

Do you have an advance directive (living will): ____ Yes ____ No

Family History

Any history of these in a parent, sibling, child, grandparent or other relative?

Stroke	Yes / No	Osteoporosis	Yes / No
Diabetes	Yes / No	Bleeding Tendencies	Yes / No
Heart Problems	Yes / No	Sickle Cell or Thalassemia	Yes / No
Heart Attack	Yes / No	Hereditary Defects	Yes / No
High Blood Pressure	Yes / No	Cystic Fibrosis	Yes / No
Abnormal Heart Rhythm	Yes / No	Arthritis or Gout	Yes / No
Blood Clots in legs or lung	Yes / No	Mental Illness	Yes / No
High Cholesterol	Yes / No	Cancer	Yes / No
Tuberculosis	Yes / No	If so, where?	

Medications (include over the counter medications, herbal remedies and vitamins)

Name	Dose	Times per day	Why do you take it?

Preferred Pharmacy

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

City/State/Zip: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Signature of Patient/Legal Guardian: _____

Date: _____