OBSTETRICS AND GYNECOLOGY NEW PATIENT HISTORY

Name: _____ Date of Birth: _____ Allergies: _____
Primary Care Physician: _____
Reason for today's visit: _____

**CURRENT MEDICATIONS:**

_____

**HEALTH MAINTENANCE:**

Procedure Date Results
Last Immunization_____
Last Blood Test _____
Last Bone Density _____
Last Colonoscopy _____

**MEDICAL HISTORY:** List any medical problems you have had and the approximate date.

_____
_____

**SURGICAL HISTORY:** List any surgeries you have had and the approximate date.

_____
Have you had a blood transfusion? Yes No If yes, when?_____

**SOCIAL HISTORY:**

Tobacco: Yes No # of cigarettes/day ____ # of years _____
Alcohol: Yes No # of drinks/dayweek____ type _____
Drugs: Yes No _____
Exercise: Yes No # of times/week _____ type _____

**FAMILY HISTORY:** Circle all that apply

Mother _____ Living / Deceased Father _____ Living / Deceased
Siblings _____
Diabetes Hypertension Heart Disease Thyroid disease Osteoporosis
Endometriosis Fibroids Other
Cancer: Breast Ovarian Uterine Colon Prostate Other:_____

**OB/GYN HISTORY:** **LMP** ( first day of last menstrual period ) _____
Pregnancies _____ Abortions _____ Miscarriages _____Premature births _____
Live births _____ Living children _____

| BIRTH DATE | TYPE OF DELIVERY | WEEKS PREGNANCY | BIRTH WEIGHT | BABY'S SEX |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Pregnancy complications?: Diabetes High blood pressure Other _____
History of depression before or after pregnancy?: yes no _____

How old were you when you had your first period?: _____
Are your cycles regular/monthly?: Yes No
How many days does your period last?: _____
If in menopause, at what age did it occur?: _____
Years of hormone replacement therapy?: _____

When was your last **PAP smear**?: _____
Have you had any abnormal PAP smears?: Yes No When? _____
Have you been told you have HPV?: Yes No When?_____
Have you had any treatments for abnormal pap smears?: Yes No
Have you received the HPV vaccine?: Yes No Date _____

When was your last **mammogram**?: _____
Have you had any abnormal mammograms?: Yes No _____
Have you had any breast biopsies?: Yes No If yes, when? _____
Do you do breast self examination?: Yes No

Have you ever had fibroids of the uterus? _____
Have you ever had ovarian cysts? _____
Do you have problems with urinating such as infections, frequency, loss of urine, blood in your urine?
_____

Have you ever had a yeast infection?: Yes No Chronic yeast? _____
Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)?: Yes No Chronic?
_____

Are you currently sexually active?: Yes No
Have you ever been sexually active?: Yes No
Have you ever been sexually abused, threatened or hurt by anyone?: _____
Are you experiencing any sexual problems?: _____

**CURRENT BIRTH CONTROL:**

None, Timing, Condoms, Diaphragm, Birth Control Pills/Patch/Ring, Implants, Depo Provera, IUD, Tubal Ligation, Vasectomy

**PAST BIRTH CONTROL:** please circle all that apply

None, Timing, Condoms, Diaphragm, Birth Control Pills/Patch/Ring, Implants, Depo Provera, IUD Tubal Ligation. Vasectomy

Have you ever been treated for any sexually transmitted infections?: _____
Gonorrhea Chlamydia Syphilis Herpes Condyloma PID

Have you ever been tested for HIV?: Yes No Date of last test: _____ Neg Pos