

Today's Date: _____

OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

A NAME: _____ **AGE:** _____ **DOB:** _____

1. Marital Status: Single Married Long-term Relationship Divorced Widowed

2. Reason for this visit: _____

3. Referring Physician: _____

4. Occupation: _____

5. Preferred phone number: _____

B MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age of first period: _____ years.

2. If your Menstrual periods are regular; periods start every: _____ days.

3. If your Menstrual periods are irregular; periods start every: _____ to _____ days. (e.g., 12 to 60)

4. Duration of bleeding: _____ days.

5. Does bleeding or spotting occur between periods? Yes No

6. Does bleeding or spotting occur after intercourse? Yes No

7. First day of last Menstrual period: _____

8. Is pain associated with periods? Yes No Occasionally

9. If yes, is it: before menses during menses both

C PREGNANCY HISTORY (ALL PREGNANCIES) HAVE NEVER BEEN PREGNANT
OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery or Termination	Duration Pregnancy	Hours of Labor	Type of Delivery	Note Complications Mother and/or Infant • Preeclampsia • Gestational Diabetes • Premature Labor • Other / Specify	(Child) Sex	(Child) Birth Weight	(Child) Present Health

D BIRTH CONTROL HISTORY

What birth control method(s) do you currently use? _____

E SEXUAL HISTORY

1. Do you have a sexual partner? No Yes: Male Female
2. Are there concerns about your sexual activity which you may want to discuss with your doctor?
 Yes No

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply or None

Surgery	Year	Surgery	Year
<input type="checkbox"/> D&C	_____	<input type="checkbox"/> Ovarian Surgery	_____
<input type="checkbox"/> Hysteroscopy	_____	<input type="checkbox"/> L cyst(s) removed ovarian	_____
<input type="checkbox"/> Infertility Surgery	_____	<input type="checkbox"/> R cyst(s) removed ovarian	_____
<input type="checkbox"/> Tuboplasty	_____	<input type="checkbox"/> L ovary removed	_____
<input type="checkbox"/> Tubal Ligation	_____	<input type="checkbox"/> R ovary removed	_____
<input type="checkbox"/> Laparoscopy	_____	<input type="checkbox"/> Vaginal or bladder repair for prolapsed or incontinence	_____
<input type="checkbox"/> Hysterectomy (vaginal)	_____	<input type="checkbox"/> Cesarean section	_____
<input type="checkbox"/> Hysterectomy (abdominal)	_____	<input type="checkbox"/> Other (specify) _____	_____
<input type="checkbox"/> Myomectomy	_____		_____

G PAST SURGICAL HISTORY (NOT OB/GYN): List all surgeries and their year or None

Surgery	Mo/Year	Complications

H PAP SMEAR/MAMMOGRAM HISTORY

1. Date of last pap smear: _____: Normal Abnormal
2. Have you had abnormal pap smears? No Yes
3. Have you had treatment for abnormal smear? No Yes
4. If yes, what type(s) of treatment have you had?

Treatment	Year	Treatment	Year
<input type="checkbox"/> Cryotherapy	_____	<input type="checkbox"/> Cone Biopsy	_____
<input type="checkbox"/> Laser	_____	<input type="checkbox"/> Loop excision (LEEP)	_____

5. Date of last mammogram: _____
6. Have you had an abnormal mammogram? No Yes

OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or None

- Venereal warts
- Endometriosis
- HPV
- Herpes-genital
- Chlamydia
- Other (specify) _____
- Syphilis
- Gonorrhea
- Pelvic Inflammatory Dis.
- Vaginal Infections

I PAST MEDICAL HISTORY: Check any that apply or None

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diabetes: | <input type="checkbox"/> Liver Disease, includes hepatitis | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diet controlled | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> Pill controlled | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Insulin controlled | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Gestational | <input type="checkbox"/> Blood Clots Leg/Thigh | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Cancer (specify) | _____ |
| <input type="checkbox"/> Kidney Disease | | _____ |

J CURRENT MEDICATIONS (include dose/amount per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?

- Smoking:** Never Former Yes, Packs/Day: _____ Cigarettes
 Years Smoked: _____ VAP Hooka
- Alcohol:** Never Former Yes, Drinks/Week: _____ Type: _____
- Illicit Drugs:** Never Former Yes Type: _____
- Caffeine Intake:** Yes No
 Coffee Tea Soda Energy Drink Chocolate Daily Intake: _____
- Lifestyle:** Are you on a specific diet? Yes No If yes, which type of diet: _____
 Do you exercise regularly? Yes No If yes, what type of exercise: _____
 Days/Week: _____ Hours/Day: _____

L DRUG ALLERGIES NO YES, LIST:

M FAMILY HISTORY or None

	Yes	Deceased (Note age & cause)	Affected Relatives (Father, Mother, Brother, Sister, Son, Daughter)
Diabetes	<input type="checkbox"/>	_____	_____
Ovarian Cancer	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	_____	_____
Endometrial Cancer	<input type="checkbox"/>	_____	_____
Breast Cancer	<input type="checkbox"/>	_____	_____
Colon Cancer	<input type="checkbox"/>	_____	_____
Other/Specify	<input type="checkbox"/>	_____	_____

N OTHER SYMPTOMS or PROBLEMS: Check any that apply or None

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Hair Growth | <input type="checkbox"/> Change in Energy |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Change in Exercise Tolerance |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Hot Flashes/Flashing | <input type="checkbox"/> Change in Urinary Function |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Physical Abuse/Domestic Violence | <input type="checkbox"/> Other (specify) _____ |

O COMPLETE ONLY IF YOU ARE PREGNANT or PLANNING TO BE PREGNANT IN THE NEAR FUTURE
Have you or the baby's father or anyone in our families ever had the following:

Down Syndrome (Mongolism)? If yes, who? _____

Other Chromosomal abnormality? If yes, specify _____

Neural tube defect (spina bifida, anencephaly)? If yes, who? _____

Hemophilia or other coagulation abnormality? If yes, who? _____

Muscular Dystrophy? If yes, who? _____

Cystic Fibrosis? If yes, who? _____

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

Father Result _____

Mother Result _____

If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?

Father Result _____

Mother Result _____

If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia?

Father Result _____

Mother Result _____

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?

Father Result _____

Mother Result _____

PATIENT SIGNATURE _____

DATE _____