shea
WOMEN'S CARE

OB/GYN HISTORY FORM

Name	Date of Birth	Age	Date
With whom may we discuss test results or therapies?			

Past Obstetrical History – deliveries, miscarriages, ectopics, and abortions.

Date (Mo./Yr.)	1	2	3	4	5	6
Birth Weight Name						
Type of delivery (Vaginal/C-sect.)						
Complications						

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No Lifetime sexual partners (#)
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Age of 1st period	Birth Control Method Are you done having children? YES / NO
Last menstrual period	Age at Menopause
Length of periods (days)	Bone Density ☐ Yes – when ☐ No
Cramps? Mild / Mod / Severe / None	Osteopenia ☐ Yes ☐ No Osteoporosis ☐ Yes No
Number of days between periods	Last Colonoscopy

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Genital Warts/HPV ☐ Syphilis ☐ HIV ☐ Trichomonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Thyroid ☐ Skin ☐ Other

Allergies – List Reaction	Medications & Dosage – Include Vitamins / Herbs

CONTINUE ON BACK SIDE

Reviewed by (Signature of Provider) _____ Date _____

Past Medical History – Do you have any of the following:

Diabetes ☐ Yes ☐ No Comments	Kidney Disease/UTI ☐ Yes ☐ No Comments	Blood Clots Leg/Lung ☐ Yes ☐ No Comments
High Blood Pressure ☐ Yes ☐ No Comments	Stroke ☐ Yes ☐ No Comments	Neurologic/Epilepsy ☐ Yes ☐ No Comments
Heart Attack/Disease ☐ Yes ☐ No Comments	Thyroid Dysfunction ☐ Yes ☐ No Comments	Gastrointestinal ☐ Yes ☐ No Comments
Rheumatic Fever ☐ Yes ☐ No Comments	Tuberculosis ☐ Yes ☐ No Comments	Hepatitis/Liver Disease ☐ Yes ☐ No Comments
Mitral Valve Prolapse ☐ Yes ☐ No Comments	Asthma ☐ Yes ☐ No Comments	Gallbladder ☐ Yes ☐ No Comments
Psychiatric ☐ Yes ☐ No Comments	Anesthesia Complications ☐ Yes ☐ No Comments	Other ☐ Yes ☐ No Comments

Immunization History

Have you had a flu vaccine?	☐ Yes ☐ No	If yes, when?_____
Have you been vaccinated against Hepatitis B?	☐ Yes ☐ No	If yes, when?_____
Have you received Gardasil vaccine?	☐ Yes ☐ No	If yes, when?_____
Have you been vaccinated against Pneumonia?	☐ Yes ☐ No	If yes, when?_____
Have you been vaccinated against Tetanus?	☐ Yes ☐ No	If yes, when?_____
Have you had chicken pox?	☐ Yes ☐ No	If no, have you been vaccinated? ☐ Yes ☐ No
Have you had Rubella (German Measles)?	☐ Yes ☐ No	If no, have you been vaccinated? ☐ Yes ☐ No
Have you had a PPD (Tuberculosis) skin test?	☐ Yes ☐ No	If yes, ☐ positive or ☐ negative

Surgeries or Hospitalizations (Reason & Year)		
1	5	9
2	6	10
3	7	11
4	8	12

Family History – Does your family have any of the following:

Breast Cancer ☐ Yes ☐ No Which relative:	Other Cancers ☐ Yes ☐ No Which relative:
Ovarian Cancer ☐ Yes ☐ No Which relative:	Birth Defects/Hereditary Disorders ☐ Yes ☐ No Which relative:
Uterine Cancer ☐ Yes ☐ No Which relative:	High Blood Pressure ☐ Yes ☐ No Which relative:
Colon Cancer ☐ Yes ☐ No Which relative:	Heart Disease ☐ Yes ☐ No Which relative:
Osteoporosis ☐ Yes ☐ No Which relative:	Diabetes ☐ Yes ☐ No Which relative:
Gynecological Problems ☐ Yes ☐ No Which relative:	Psychiatric Disorder ☐ Yes ☐ No Which relative:

Social History

Occupation	Marital Status ☐ Widowed ☐ Single ☐ Married ☐ Divorced	Social Drug Use ☐ Yes ☐ No Type: Amount: How Often:
Cigarettes ☐ Yes ☐ No For how long:	Pack/Day: Quit date:	Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship
Alcohol ☐ Yes ☐ No Amount:	Type: How often:	Advance Directives ☐ Yes ☐ No If yes, please bring copy for your chart. ☐ Yes ☐ No

Review of Systems (Check all that apply) – Negative except where noted below:

Constitutional ☐ Weight Loss ☐ Fever ☐ Fatigue ☐ Other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ Urinary frequency/urgency ☐ Caffeine/day ☐ Other
Neck ☐ Pain ☐ Difficulty swallowing ☐ Lumps ☐ Other	Skin/Breast ☐ Rash ☐ Lumps in breast ☐ Nipple discharge ☐ Pain in breast ☐ Other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ Other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ Other
Respiratory ☐ Cough ☐ Pain with breathing ☐ Shortness of breath ☐ Other	Lymphatic ☐ Lumps in groin, under arms, or in neck ☐ Other