Advanced Women's Health
OB/GYN

Patient Name: _____ Date of Birth: _____

Age: _____ Today's Date: _____

MEDICAL HISTORY FORM

RELATIONSHIP STATUS:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Committed Relationship

Are you currently sexually active? _____ Number of current partners: _____ Interested in Men, Women, or Both: _____

GYN HISTORY:

1st day of last period: _____ ☐ Regular Cycle ☐ Irregular Cycle Length of Cycle: _____ ☐ Heavy Flow ☐ Normal Flow ☐ Light Flow

PREGNANCY HISTORY:

Total Pregnancies: _____ # Full Term: _____ # Preterm: _____ # Living children: _____

Vaginal Deliveries: _____ # C-Sections: _____ # Miscarriages: _____ # Abortions: _____

Complications: _____

BIRTH CONTROL: *(Check ALL that apply)*

☐ **Natural Family Planning** ☐ **Condoms** ☐ **Diaphragm** ☐ **Pills** ☐ **Patch** ☐ **NuvaRing** ☐ **Nexplanon** ☐ **IUD**

☐ **Depo Provera** - ***Date of last injection:*** _____ ☐ **Tubal ligation** ☐ **ESSURE** ☐ **Vasectomy** ☐ **Hysterectomy** ☐ **Abstinence**

Are you happy with your current method of birth control? ☐ Yes ☐ No

MEDICAL HISTORY: *(Please check if YOU have ever had any of the following)*

☐ Abnormal pap smear ☐ High Blood Pressure ☐ Thyroid disorder ☐ Blood Clot ☐ Fibroids ☐ Cancer ☐ Infertility ☐ Heart disease

☐ Sexually Transmitted Disease ☐ High cholesterol ☐ Kidney disease ☐ Migraines ☐ Pelvic infection ☐ Diabetes ☐ Depression ☐ Lung disease

☐ Alcoholism ☐ Polycystic Ovary Syndrome ☐ Liver Disease ☐ Drug addiction ☐ STD: _____ ☐ Other: _____

FAMILY HISTORY:

(*Please check appropriate box if a family member – Sibling, Parents, Grandparents, etc.,- currently has or has had one of these illnesses. Check **ALL** that apply.*) ***Write the Name of Family member(s) with illness on lines.***

☐ Breast Cancer: _____
☐ Ovarian Cancer: _____
☐ Uterine Cancer: _____
☐ Cervix Cancer: _____
☐ Stroke: _____
☐ Birth Defects: _____
☐ High Blood Pressure: _____
☐ Diabetes: _____
☐ Bleeding Disorder: _____
☐ Alcoholism: _____
☐ Other: _____

CURRENT MEDICATIONS: *(Please list medications that you take (write on back if you need more space)*

_____

_____

Allergies? _____ ☐ NO ALLERGIES

SURGICAL HISTORY

_____

_____

VACCINATIONS:

Have you had any of the following vaccinations? ☐ Gardasil (HPV) ☐ Flu (within 1 year) ☐ Hepatitis B ☐ Varicella (chicken pox)

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HEALTH MAINTENANCE

1.) When was your last pap smear? _____

2.) Have you ever had an abnormal pap? □ **Yes** □ **No**

3.) Have you ever had a Colposcopy? □ **Yes** □ **No**

4.) When was your last mammogram? _____

5.) Have you ever had a colonoscopy? □ **Yes** □ **No**

6.) When was your last bone scan? _____

7.) Have you ever smoked? □ **Yes** □ **No**

8.) Do you smoke? □ **Yes** □ **No**

How often? _____

Are you interested in quitting? □ **Yes** □ **No**

9.) Do you drink alcohol? □ **Yes** □ **No**

How often? _____

10.) Do you use drugs? □ **Yes** □ **No**

History of drug abuse? □ **Yes** □ **No**

11.) Do you exercise? □ **Yes** □ **No**

How often? _____

12.) Have you ever been abused? □ **Yes** □ **No**

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