Advanced Women's Health OB/GYN

MEDICAL HISTORY FORM

Patient Name:________________________ **Date of Birth:** __________ **Today's Date:** ____________

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:

For each Pregnancy, Please list child's Date of Birth, Any complications, The doctor who delivered baby, if it was vaginal birth or c-section.

PREGNANCY #1: _

PREGNANCY #2: —

PREGNANCY #3: —

PREGNANCY #4: —

PREGNANCY #5: —

PREGNANCY #6: —

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: (check all that apply)

☐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:

FAMILY MEMBER	STATUS	DOB	AGE	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	MENTAL ILLNESS	CANCER	ALCOHOLISM
FATHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐
MOTHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐
PATERNAL GRANDFATHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐
PATERNAL GRANDMOTHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐
MATERNAL GRANDFATHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐
MATERNAL GRANDMOTHER	☐Alive ☐Deceased			☐	☐	☐	☐	☐	☐

MEDICAL HISTORY FORM

Advanced Women's Health OB/GYN

Patient Name:_________________________ **Date of Birth:** _________

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? o Gardasil (HPV) o Flu (within 1 year) o Hepatitis B o Varicella (chicken pox

HEALTH MAINTENANCE:

1.) When was your last pap smear?______

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

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

4.) When was your last mammogram?____

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

6.) When was your last bone scan?______

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

8.) Do you smoke? **o Yes o No**
How often? ______________________
Are you interested in quitting? **o Yes o No**

9.) Do you drink alcohol? **o Yes o No**
How often? ______________________

10.) Do you use drugs? **o Yes o No**
History of drug abuse? **o Yes o No**

11.) Do you exercise? **o Yes o No**
How often? ______________________

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

13.) Occupation: ☐**Unemployed** ☐**Employed Full-time** ☐**Employed Partime** ☐**Student**

Where do you work? ___________________________

What is your position? _________________________