Date:________________

At this time, we would like to formally welcome you to Advanced Care for Women. As you are new to our office, please fill this form out to the best of your ability to inform us fully about you and your health history to help us ensure you receive the best care. If at any point you have questions, don't hesitate to ask for assistance.

OB/GYN Health History Form

Name:______________________________ D.O.B.:_____________ E-Mail:_____________________________

Marital Status (circle one): Single Married Divorced Separated Widowed

Reason for today's visit:____

Medical History: Have you ever had any of the following?

- ❐ Anemia
- ❐ Heart Disease/Attack
- ❐ High Blood Pressure
- ❐ Stroke
- ❐ High Cholesterol
- ❐ Mitral Valve Prolapse
- ❐ Bleeding Problems
- ❐ Blood Clots in Lungs/Legs
- ❐ Gall Bladder Disease
- ❐ Liver Disease/Hepatitis
- ❐ Kidney Infections
- ❐ Bladder Infections
- ❐ Pelvic Infections
- ❐ Arthritis
- ❐ Chicken Pox
- ❐ Epilepsy/Seizures
- ❐ Migraines
- ❐ Depression/Anxiety
- ❐ Drug or Alcohol Problem
- ❐ Diabetes
- ❐ Asthma
- ❐ Osteopenia
- ❐ Osteoporosis
- ❐ Pneumonia
- ❐ Tuberculosis
- ❐ Sickle Cell Disease
- ❐ Thyroid Problem
- ❐ Blood Transfusion
- ❐ Genetic Condition
- ❐ Cancer
- ❐ PCOS
- ❐ GERD/Reflux
- ❐ Other

Medications: Please list all medications and dosages you are taking, including over-the-counter medications, vitamins, and herbal remedies:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Allergies: Please list any allergies to medicines, environmental, or foods; and your reactions to them:

____

____

Surgical History: Please list all surgeries with dates:

____

____

Obstetrical History:

How many times have you been pregnant?____ # of Full term deliveries?____ # of Preterm Deliveries (<37 weeks)?____ # of miscarriages?____ # of abortions?____ # of (ectopic) tubal pregnancies?___ # of Cesarean sections?____ # of deliveries with forceps/vacuum?____

Please list any special pregnancy problems: ____

GYN History:

First day of last menstrual period:_______________ Length of period on average:_____ Number of days in between periods:____ Age of first period:____ Are your periods painful?____ Irregular?____ Heavy?____

When was your last PAP test?________________ Have you ever had an abnormal PAP?_____ If so, what was the result?_____________ When was it?______________ What procedures done?_________________________

Are you currently sexually active?_______ What is your sexual orientation?_____________________________

What age did you begin sexual activity?______ Number of partners?_____

Are you currently using birth control?______ If so, which method?______________________________________

Are you satisfied with your current method?____________________________ Trying to get pregnant?________

Have you ever had any of the following sexually transmitted diseases (STDs)?

____Chlamydia ____Gonorrhea ____Herpes ____HPV ____Syphillis ____Hepatitis B ____Hepatitis C

____ HIV ____ Trichomonas

If you've had a mammogram, when was your last one?______________ Was it normal?_________

If you've had a bone density scan, when was your last one?______________ Was it normal?__________

If you've had a colonoscopy, when was it done?________________

Family History: Please list any close relatives with a history of the following:

Diabetes		Breast Cancer	
High Blood Pressure		Cancer of Uterus/Ovaries	
Heart Attack		Blood Clot/Bleeding Problems	
Stroke		Seizures	
Thyroid Disease		Colon Cancer	
Osteoporosis		Other	

Social History:

Smoking: ___ yes ___no Packs/day:_____ Years:_______ Quit Date:__________

Alcohol: ___yes ___no Drinks/day:_____ Week:______

Drug Use: ___yes ___no Which Drugs:________________________ Years:______ Quit Date:_________

Caffeine: ___yes ___no Cups/day:____________ Week:_____

Has anyone close to you ever threatened to hurt you?____

Have you ever been forced to have sex?____

Have you ever been physically abused?____