

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?

- | | | | |
|------------------------------------------------|----------------------------------------------------|-----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Clots in Lungs/Legs | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Depression/Anxiety Problem | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Drug or Alcohol Problem | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pelvic Infections | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic Condition |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> PCOS |
| | | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> GERD/Reflux |
| | | | <input type="checkbox"/> 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? # _____ Cesarean Sections # _____

Full term deliveries # _____ Preterm deliveries (-37) # _____ Vacuum/forceps deliveries# _____

Miscarriages # _____ Abortions # _____ Ectopic (tubal) pregnancies # _____

Deliveries:

Please fill out for each pregnancy including miscarriage

Delivery date, # of weeks when delivered, gender, weight of baby, vaginal/c-section, place of birth

1 _____, _____, _____, _____, _____, _____

2 _____, _____, _____, _____, _____, _____

3 _____, _____, _____, _____, _____, _____

4 _____, _____, _____, _____, _____, _____

5 _____, _____, _____, _____, _____, _____

6 _____, _____, _____, _____, _____, _____

7 _____, _____, _____, _____, _____, _____

8 _____, _____, _____, _____, _____, _____

9 _____, _____, _____, _____, _____, _____

10 _____, _____, _____, _____, _____, _____

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 ____ Syphilis ____ 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? _____