The OB/GYN Specialists
Patient Medical History

Name:_____ DOB: _____

Please list any present medications: _____

_____

Medical History

Please check all that apply:

[ ] Anxiety	[ ] Asthma	[ ] Depression	[ ] Melanoma	[ ] Epilepsy
[ ] Fibroids	[ ] Stroke	[ ] Heart Murmur	[ ] Colonic Polyps	[ ] Kidney Stones
[ ] Cancer, Breast	[ ] Cancer, Colon		[ ] Cancer, Rectal	[ ] Cancer, Ovarian
[ ] Cancer, Uterus	[ ] Cancer, Endometrial		[ ] Cancer, Cervical	

Allergies:

Please list any drug allergies: _____

GYN History:

Last Pap Smear (mm/yyyy): _____

Result of last pap: [ ] Normal [ ] Abnormal [ ] No pap ever done

Self Breast Exam: [ ] Monthly [ ] Do not perform [ ] Sometimes

Have you had a Gardisil HPV Vaccine: [ ] Yes [ ] No

Last Mammogram Date (mm/yyyy): _____

Result of last Mammogram: [ ] Normal [ ] Abnormal [ ] No mammo ever done

Last Dexa (Bone Density) scan (mm/yyyy): _____

Result of last Dexa scan: [ ] Normal [ ] Osteopenia[ ] Osteoporosis

Last colonoscopy (mm/yyyy):_____

Menstruation:

Age of Onset: At what age did your periods start? _____

LMP: Date of last menstrual period (dd/mm/yy): _____

(If menopausal, skip to Menopause section now)

Time Between Periods: [ ] Irregular [ ] 21- 32 Days apart

[ ] > 45 Days apart [ ] < 21 days apart

[ ] 33 – 44 Days

Duration: How long does your period last? [ ] < 7 days [ ] 2 - 7 days [ ] 1 day

Pad / Tampon Use Per Day: [ ] 1-3 [ ] 4-6 [ ] 7+

Associated Signs/ Symptoms: How would you describe your period:

[ ] with severe pain [ ] with moderate pain

[ ] with mild discomfort [ ] without discomfort/ pain

[ ] heavy [ ] light

Menstruation Symptoms:

Premenstrual Syndrome: [ ] Yes [ ] No

If yes, please mark any symptoms you are experiencing:

[ ] Withdrawal [ ] Weight gain [ ] Tension [ ] Pelvic pain

[ ] Mood swings [ ] Tiredness [ ] Headaches [ ] Depression

[ ] Bowel changes [ ] Bloating [ ] Anxiety [ ] Changes in desire

[ ] Breast swelling/discomfort

Menopause: [ ] Yes [ ] No

If yes, began at age: _____

Current menopausal symptoms:

[ ] None [ ] Headache

[ ] Hot flashes [ ] Irritability

[ ] Memory Loss [ ] Loss of Sexual Desire

[ ] Weight Gain [ ] Vaginal dryness

Birth Control:

[ ] Condoms

[ ] Oral contraceptive pills Indicate which pill: _____

[ ] Mirena IUD [ ] Paraguard IUD

[ ] Skyla IUD [ ] Diaphragm

[ ] Nuvaring [ ] Bilateral Tubal Ligation

[ ] Vasectomy [ ] None

[ ] Depo-Provera [ ] Ortho Evra Patch

[ ] Spermicide [ ] Nexplanon

If using an IUD or Nexplanon, please list the date of insertion (mm/yy): _____

Sexual activity:

[ ] Currently sexually active [ ] Not currently sexually active

Total Number of Sex Partners: _____

[ ] Past history of sexual abuse: _____

_____

Currently or in the past, I have had sex:

[ ] With men [ ] With women [ ] With both men and women

Sexually Transmitted Infections (STI's)?

[ ] None

[ ] Human Papilloma Virus (HPV)

[ ] Chlamydia

[ ] Human Immunodeficiency Virus (HIV)

[ ] Hepatitis B

[ ] Syphilis

[ ] Herpes Simplex Virus (HSV)

[ ] Gonorrhea

[ ] Trichomoniasis (Trich)

[ ] Hepatitis C

OB History

Total pregnancies: _____ Total living children: _____

Total full term pregnancies: _____ Total pre term pregnancies: _____

Total miscarriages/abortions: _____

Total Ectopic Pregnancies: _____

Please fill out the following to the best of your recollection regarding prior pregnancies:

Birth Date	# Weeks Pregnant at Birth	Hours in Labor	Birth Weight	Anesthesia	Deliver Method	Delivery Location & Provider
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						

Surgical History

Please list any previous surgeries and c-sections (include minor surgeries like wisdom teeth, appendix, etc.). Please indicate approximate date:

_____

_____

_____

Have you ever had a blood transfusion? [ ] Yes [ ] No

Hospitalizations:

Please list any hospitalizations:

_____

_____

_____

Family History

Please check all that apply for the corresponding family member. Under status, please indicate "alive", "deceased", or "unknown". Please put an "X" in the appropriate boxes below.

	Status	Year of Birth	Age	Heart Disease	Breast Cancer	Ovarian Cancer	Colon Cancer	Bleeding Disorder	Blood Clotting Disorder
Mother									
Father									
Sister #1									
Sister #2									
Brother #1									
Brother #2									
Son #1									
Son #2									
Daughter #1									
Daughter #2									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Maternal Aunt									
Maternal Uncle									
Paternal Aunt									
Paternal Uncle									
Cousin									

Social History:

Smoking:

Current smoking status: [ ] Current smoker [ ] Former smoker

[ ] Nonsmoker [ ] Current everyday smoker [ ] Current some day smoker

[ ] Smoker, status unknown [ ] Unknown if ever smoked

If you currently smoke, how often do you smoke cigarettes?

[ ] Every day [ ] Some days, but not every day

If you currently smoke, how many cigarettes a day do you smoke?

[ ] 5 or less [ ] 6-10 [ ] 11-20 [ ] 21-30 [ ] 31 or more

If you currently smoke, how soon after waking do you smoke your first cigarette?

[ ] within 5 minutes [ ] 6 – 3- minutes [ ] 31 – 60 minutes [ ] after 60 minutes

Are you interested in quitting?

[ ] Ready to quit [ ] Thinking about quitting [ ] Not ready to quit

Alcohol:

Did you have a drink containing alcohol in the past year?: [ ] Yes [ ] No

How often did you have a drink containing alcohol in the past year?

[ ] Never [ ] Monthly or less [ ] 2-4 times a month

[ ] 2-3 times a week [ ] 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks [ ] 3-4 drinks [ ] 5-6 drinks [ ] 7-9 drinks [ ] 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? [ ] Y [ ] N

Caffeine Intake: [ ] None [ ] 1-2 cups per day [ ] 2-3 cups per day

[ ] 3-4 cups per day [ ] More than 4 cups per day

Any history of domestic violence?

[ ] None [ ] History in the past [ ] Has restraining order

[ ] Feel unsafe at home [ ] Have a safety plan

Has your current partner ever threatened you or made you feel afraid?

[ ] Yes [ ] No

Does your current partner or someone important to you hurt you physically or emotionally? [ ] Yes [ ] No

Exercise Frequency: [ ] Never [ ] Occasionally [ ] 1-2 times per week

[ ] 2-3 times per week [ ] 3-4 times per week [ ] 4-7 times per week

Any history of verbal abuse?

[ ] None [ ] Occasional [ ] Frequent

[ ] Seeking counseling [ ] Has safety plan

If you are currently pregnant, please answer the questions below:

- Date of first positive pregnancy test *(mm/dd/yy)*: _____
- List any medications you have taken during this pregnancy: _____

  _____
- Were you on the pill or using contraception when you became pregnant? [ ] Y [ ] N
- Name of baby's father:_____
- Name of partner: _____
- How much alcohol, including beer, have you drank during this pregnancy?
  (if none, write none) _____
- Do you have a cat? [ ] Yes [ ] No
- What is the baby's father's family/ethnic background? _____

  _____
- Have you or the baby's father ever been tested for Tay-Sachs, Canavan, or Gaucher's Disease?
  [ ] Yes [ ] No
- Have you or the baby's father ever been screened for Sickle Cell Disease?[ ] Yes [ ] No
- Does the baby's father have any family history of birth defects? [ ] Yes [ ] No
- Will you be age 35 or older when the baby is born? [ ] Yes [ ] No
- Have you or the baby's father or anyone in either of your families ever had the **following:**

Down Syndrome	[ ] Yes [ ] No
Spina Bifida	[ ] Yes [ ] No
Hemophilia	[ ] Yes [ ] No
Muscular Dystrophy	[ ] Yes [ ] No

Do you or the father of the baby have a <u>family</u> history of the following (only check one of the options below if the relationship is mother, father, maternal or paternal grandparent, sister, or brother and list the relationship next to the disease):

Diabetes	[ ] No [ ] Yes	Relationship _____
Heart Disease	[ ] No [ ] Yes	Relationship_____
Hypertension	[ ] No [ ] Yes	Relationship_____
Cancer Type	[ ] No [ ] Yes	Relationship_____
Birth Defects	[ ] No [ ] Yes	Relationship_____

Blood Clot Issues [ ] No [ ] Yes Relationship_____

- Have you or the baby's father ever had a child born with a defect not listed above?
  [ ] Yes [ ] No
  If "yes", please describe: _____
  _____
- Have you or the baby's father ever had a stillbirth?
  [ ] Yes [ ] No
- Have you or the baby's father, even in a previous relationship, experienced two or more miscarriages? [ ] Yes [ ] No
- Have you or the baby's father ever been screened for cystic fibrosis, or is anyone in either of your families affected by cystic fibrosis? [ ] Yes [ ] No
- Do you or the baby's father have any close relatives who are mentally disabled? [ ] Yes [ ] No
  If so, whom? _____

Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above?

[ ] Yes [ ] No

If "yes", please describe: _____

Providers in this practice will administer blood or blood products in the event of a life-threatening hemorrhage. Do you object to blood or blood products in the event of a life threatening hemorrhage?

[ ] Yes [ ] No

Is there any other information or suggestions you can provide that could make your obstetrical care and delivery a more memorable experience?

_____

_____

_____