OB/GYN ASSOCIATES OF SOUTHERN IN

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WOMEN'S HEALTH HISTORY

Name_____ Date of Birth ___/___/___ Highest Grade of Education _____ Date ___/___/___

Past Medical History	Check box if you have ever had any of the following:
☐ Cancer	☐ Blood Clot in Leg or Chest
☐ Stroke	☐ Ulcer, Irritable Bowel, or Other GI Disorder
☐ Diabetes	☐ Hepatitis or Liver Disease
☐ Migraines	☐ Osteoporosis
☐ Anemia	☐ Thyroid Disease
☐ Asthma	☐ Other Hormone Disorder
☐ Kidney Disease	☐ Tobacco Use: Age Started:_____ Age Quit:_____Amount Per Day____
☐ High Blood Pressure	☐ Alcohol Use: ___ None ___ Socially ___ Occasionally ___ Daily
☐ Gallbladder Disease	☐ Other Drug Use (Such as marijuana, etc.) _____
☐ Endometriosis	☐ Genital Warts
☐ Eating Disorder	☐ Herpes
☐ Depression	☐ Chlamydia
☐ Panic Attacks	☐ Gonorrhea
☐ Physical or Emotional Abuse	☐ Other Sexually Transmitted Disease
☐ Sexual Abuse	☐ Abnormal Pap Smear
☐ Heart Disease or Heart Attack	☐ Other:

Family History Fill in box if a blood relative has had. Write Initials after condition. F=Father M=Mother GM=Grandmother GF= Grandfather S=Sibling C=Child O=Other relative	
☐ High Blood Pressure	☐ Heart Attack Before Age 55 in Father or Brother
☐ Osteoporosis	☐ Heart Attack Before Age 65 in Mother or Sister
☐ Endometriosis	☐ Depression/Panic Attacks/Suicide, Etc.
☐ Stroke	☐ Alcoholism or Other Chemical Dependency
☐ Diabetes	☐ Birth Defect or other Genetic Condition
☐ Cancer	☐ Other:
☐ Blood Clot in Chest or Legs	

Marital History (Please List All Marriages)

Spouse's Name	Dates Married	Spouse's Name	Dates Married

Allergies

Are you allergic to any medications or vaccines? ☐ Yes ☐ No If yes please list:

Are you allergic to latex? ☐ Yes ☐ No

Food allergies or intolerances: (please list)

OB/GYN/Breast Surgery & Procedure History	Date	Place/MD

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Other Surgeries, Hospitilizations & Injuries	Date	Place/MD

Obstetrical History

Please list IN ORDER EACH TIME you have been pregnant, including miscarriages and terminations. List approximate number of weeks each pregnancy lasted, childrens' names & weights.

Year	# Weeks Pregnant	Name of Child	Weight	Place/MD

Gynecological History

Age of your first period: _____ Age of menopause:_____

When was the first day of your last period: _____/_____/_____

Menstrual Cramps ☐ None ☐ Mild ☐ Mod. ☐ Severe

Mo/Year of last Pap Smear _____/_____ ☐ Never Mo/Year of last Colonoscopy _____/_____ ☐ Never

Mo/Year of last Mammogram _____/_____ ☐ Never Mo/Year of last DXA Scan _____/_____ ☐ Never

Contraceptive or Hormone Replacement Therapy (HRT) History

Past/Current Methods	Dates	Side Effects	Why Stopped/Satisfaction?

Medications History **(List all medications you are taking, including prescriptions, over-the-counter drugs, hormones, and "as needed" Medicines.)**

Immunization History

When was your last Tetanus shot? _____/_____/_____ ☐ Don't know

Are you immune to Rubella (3-day measles)? ☐ Yes ☐ No ☐ Don't know

Have you ever had chicken pox? ☐ Yes ☐ No ☐ Don't know

Have you been vaccinated for chicken pox? ☐ Yes ☐ No Date:

Have you been vaccinated for Hepatitis B? ☐ Yes ☐ No Date:

Have you been vaccinated for pneumonia? ☐ Yes ☐ No Date:

Have you ever had a positive TB skin Test? ☐ Yes ☐ No Date:

Have you started or completed the Gardasil Series? _____ Completed (3 injections) _____Started not completed (# of injections _____)