Please fill out your Health History **fully**. YES!—We understand we ask for detailed personal information—having a thorough history helps us provide you with the BEST possible care!

GYN HISTORY

Last Menstrual Period (date): _____

Menstrual History: Age at first period _____

How many days apart are your periods (from the start of one period to the next)? _____ to _____days apart

How many days do you bleed? _____ days

How is the flow? ☐ Light ☐ Medium ☐ Heavy

PMS Symptoms: ☐ No ☐ Yes:_____

Menstrual cramps: ☐ No ☐ Yes:_____

Pain with intercourse: ☐ No ☐ Yes:_____

Birth Control Method:

☐ Oral Contraceptive Pills (name):_____

☐ NuvaRing

☐ OrthoEvra (patch)

☐ Depo-Provera (injection every 3 months)

☐ Mirena IUD (5 year, hormonal)

☐ Copper T IUD (10 year, nonhormonal)

☐ Condoms

☐ Diaphragm ☐ Cervical Cap

☐ Natural Family Planning (type): _____

☐ Tubal Ligation

☐ Vasectomy

☐ None, Desiring Conception

☐ None, OK with pregnancy

☐ None, NOT Desiring pregnancy

☐ None: ☐ Menopause ☐ Hysterectomy

PAP History:

History of abnormal PAPs?: ☐ Never

☐ Yes (Mo/Yr):_____

Was a biopsy done? ☐ Yes ☐ No ☐ Unknown

Any treatment? ☐None

☐ Cryotherapy (Freeze the cervix)

☐ Cone biopsy (surgery in OR)

☐ LEEP ☐ LASER

Breast History:

Do you perform Self Breast Exams? ☐ Yes ☐ No

Breast problems:_____

Menopause History:

Age at menopause: _____

Have you used Hormone Replacement?

☐ No ☐ Yes: (Types)_____

Mother's menopause age:_____

Sexual History:

Have you been sexually active in the **last year**?

☐ Yes ☐ No

Orientation: ☐ Heterosexual ☐ Bisexual

☐ Homosexual ☐ Other

How long have you been sexually active with your **current** partner? _____

Have you or your partner been sexually active with **anyone else** during this time? ☐ No☐ Yes

In the **last year**, how many partners have you had?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5-10 ☐ >10

How many partners have you had in your **lifetime**?

☐ 0 ☐ 1 ☐ 2-5 ☐ 6-10 ☐ >10

Do you **ALWAYS** use condoms? ☐ Yes ☐ No

STD History:

Have you ever had any of the following?:

☐ Trichomonas ☐Hepatitis B ☐Hepatitis C

☐ Chlamydia ☐ Syphilis ☐HIV/ AIDS

☐ Gonorrhea ☐Herpes: ☐ Oral ☐ Genital

☐ HPV ☐ Molluscum contagiosum

Have you been tested for STDs since the start of your most recent relationship? ☐ Yes ☐ No

Last STD testing (Mo/Yr) :_____

☐ Vaginal ☐ Blood ☐ Urine

Do you have any tattoos? ☐ None ☐ Yes

Have you been tested for Hepatitis C since the tattoo?

☐ No ☐ Yes

If you have NEVER been pregnant, is this by choice? ☐ Yes ☐ No

PREVIOUS PREGNANCIES

PLEASE LIST ALL PREGNANCIES INCLUDING MISCARRIAGES, ABORTIONS OR OTHER FAILED PREGNANCIES

DATE		LENGTH OF PREG (<37w?)	HOURS IN LABOR	TYPE OF DEL		ANESTHESIA TYPE	DOCTOR/ CITY	BABY'S GENDER	BABY'S WEIGHT ≥9#?	CHILD'S NAME	PROBLEMS WITH MOM AND/OR BABY
				Vag	CSx						
1											
2											
3											
4											
5											
6											

	YES	NO
1. WERE ANY BABIES BORN WITH BIRTH DEFECTS?		
2. DID ANY BABIES DEVELOP JAUNDICE, INFECTIONS OR OTHER PROBLEMS IN THE FIRST 2 WEEKS OF LIFE?		
3. DID YOU HAVE DIABETES, HIGH BLOOD PRESSURE, BLEEDING, DEPRESSION OR OTHER PROBLEMS DURING A PREGNANCY?		
4. HAVE YOU OR THE BABY'S FATHER HAD A CHILD THAT DIED AROUND THE TIME OF DELIVERY OR IN THE FIRST YEAR OF LIFE?		

ALLERGIES ☐ No Known Drug Allergies

Medication	Allergic Reaction		Medication	Allergic Reaction

MEDICATIONS ☐ None (please include prescription, vitamin, herbal products, and over-the-counter meds)

Name of Med	Dose (mg/pill)	How many pills in:		Reason for taking Medication?
		Morning?	Evening?	
Calcium ☐ No ☐ Yes				
Vitamin D ☐ No ☐ Yes				
Multivitamin ☐ No ☐ Yes				

PAST SURGERIES ☐ None

Year	Name or Type of Surgery	Reason for Surgery	Open procedure, Laparoscopic, or Robotic? Complications during or after surgery?

Please include medical problems and history of hospitalizations:

MEDICAL HISTORY Do **YOU** have a history of:	YES?	Age at diagnosis	Managing Physician	Comments
Birth Defect	☐			
Asthma	☐			
Breast Cancer	☐			
Breast Problems	☐			
Twins or Multiple Births	☐			
Pelvic Organ Cancer (type?)	☐			
Colon Cancer	☐			
Other Cancers (type?)	☐			
Diabetes Type 1	☐			
Diabetes Type 2	☐			
Heart Attack	☐			
Stroke	☐			
High Blood Pressure	☐			
Lung Problems	☐			
Kidney Disease	☐			
GastroIntestinal Problems	☐			
Blood Transfusions	☐			
Osteoporosis	☐			
Thyroid Disease	☐			
Depression	☐			
Anxiety	☐			
Anemia/Bleeding/bruising	☐			
Blood clots in Lung or Leg	☐			
Clotting Disorder (type?)	☐			
Trauma	☐			
Other:	☐			
Other:	☐			
Other:	☐			

SOCIAL HISTORY

SUBSTANCE USE			Year Quit
Tobacco—Smoking	☐ Never	_____ packs/day x _____ years	
Tobacco—Chewing	☐ Never	_____ cans/day x _____ years	
Alcohol	☐ Never	_____ drinks/_____ ☐ Beer ☐ Wine ☐ Liquor	
Illicit drugs	☐ Never	Which drugs?	

Marital status: ☐ Single ☐ Married ☐ In a relationship ☐ Live with partner
☐ Separated ☐ Divorced ☐ Widowed

Education Level: _____ Degree:_____

Employer: _____ Job Title/Description: _____ ☐ Full-time ☐ Part-time

Do you Exercise regularly? ☐ No ☐ Yes

Type of Exercise: ☐ Aerobic:_____ How many times **weekly**?___ How many **minute**s each time? ___
☐ Weight-training:_____ How many times **weekly**?___ How many **minutes** each time? ___

Do you use the following? ☐ Chiropractor ☐ Massage ☐ Acupuncture

Do you use the following regularly? ☐ Seatbelts ☐ Sunscreen ☐ Smoke detectors ☐ Carbon Monoxide detectors

Do you feel safe at home? ☐ Yes ☐ No

Has anyone (including your partner) tried to hurt you in the past? ☐ No ☐ Yes

Religious preference: ☐ No ☐ Yes _____

Are you **CURRENTLY** experiencing any of the following?

General
- □ Chills
- □ Fever
- □ Forgetfulness
- □ Loss of Sleep
- □ Sweats
- □ Weight change

Skin
- □ Change in moles
- □ Sore that won't heal
- □ Scars

Head, Eyes, Ears, Nose, Throat
- □ Headaches
- □ Dizziness/Passing Out
- □ Visual changes
- □ Loss of hearing
- □ Difficulty swallowing
- □ Hoarseness

Lungs, Heart
- □ Shortness of breath
- □ Chest pain
- □ Irregular/Rapid heart beat
- □ Leg pain/swelling/poor circulation
- □ Varicose veins

Abdomen
- □ Appetite poor/excessive
- □ Bloating/Indigestion
- □ Nausea/Vomiting
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids
- □ Bloody stool/rectal bleeding

Kidney/Bladder
- □ Urinary tract infection
- □ Kidney stones
- □ Blood in urine
- □ Difficulty with urinating
- □ Leaking urine
- □ Going too often

Muscles/Joints/Bone
- □ Joint pain/swelling/stiffness
- □ Muscle cramps:_____
- □ Muscle weakness:_____

Nervous System
- □ Numbness:_____
- □ Seizure/Convulsions

FAMILY HISTORY Place an X in the column of the family member(s) who has(have) the given condition.	YES?	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	COMMENTS
Birth Defect	☐													
Asthma	☐													
Breast Cancer	☐													AGE at diagnosis:
Breast Problems	☐													
Twins or Multiple Births	☐													
Pelvic Organ Cancer (type?)	☐													
Colon Cancer	☐													AGE at diagnosis:
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GastroIntestinal Problems	☐													
Blood Transfusions	☐													
Osteoporosis	☐													
Thyroid Disease	☐													
Depression	☐													
Anxiety	☐													
Anemia/Bleeding/bruising	☐													
Blood clots in Lung or Leg	☐													
Clotting Disorder (type?)	☐													
Other:	☐													
Other:	☐													