Obstetrics & Gynecology Specialty
Patient Health History

Patient Name: ____ DOB: ________________

Obstetrical History

Are You Pregnant? ☐ Yes, ☐ 1st ☐ 2nd ☐ 3rd Trimester ☐ No ☐ Unknown

Pregnancy History
Your age when 1st child was born: _________

Pregnancies: # _____ Number of Deliveries: # _____

Vaginal Delivery: # _____ C-Section: # _____ Abortions: # _____

Conditions or Complications of Pregnancy: ______________________________

____

Gynecological History
Age at first Menses: _________

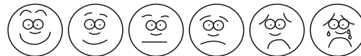
Duration of each period: _________ Days ☐ Regular ☐ Irregular

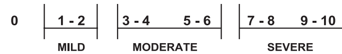
Birth Control Method: __________________ ☐ Pills ☐ Hormones

Years birth control used: _________ Currently Using: ☐ Yes ☐ No

Do You Have Pelvic Pain? ☐ Yes ☐ No ☐ Unknown

Pain Level:
(Indicate pain level on graph)

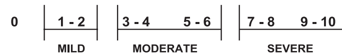




Are You Post-Menopausal? ☐ Yes ☐ No ☐ Unknown

If menopausal, age at last menses: _________ Date: ______________________

Impact of bleeding on daily activities:
(Indicate bleeding level on graph)



Gynecological Illness History
Please check off any conditions that you have had and give dates if appropriate.

Gynecological Illness	Yes	No	Date	Gynecological Illness	Yes	No	Date
Pelvic Inflammatory Disease				Last Pap-Smear			
Ovarian Cyst				Prior Abnormal Pap-Smear			
Uterine Fibroids				Fertility Problems			
Endometriosis				Herpes			
Human Papilloma Virus (HPV)				Sexually Transmitted Diseases			
Routine Breast Cancer Screening				Have you had a mammogram?			
Breast Lump Left or Right				Have you had an ultrasound?			
Mass in armpit (axilla) L or R				Have you had a biopsy?			
Breast Pain/Discomfort							
Nipple Discharge				Have you had any Surgeries?			
Abnormal Mammogram							
Breast Skin Changes				Other:			
Bloody Nipple Discharge				Other:			

Patient Name: ______________________________ DOB: ______________

Breast Disease ☐ Yes ☐ No ☐ Unknown

Deep Vein Thrombosis (DVT): ☐ Yes ☐ No ☐ Unknown

Pulmonary Embolism ☐ Yes ☐ No ☐ Unknown

Liver Disease ☐ Yes ☐ No ☐ Unknown

Diabetes: ☐ Yes ☐ No ☐ Unknown

Diabetes Type: ☐ Type 1 ☐ Type 2

Diabetes Control: ☐ Controlled ☐ Uncontrolled ☐ Unknown

Abnormal EKG: ☐ Yes ☐ No ☐ Unknown

Abdominal Hernias: ☐ Yes ☐ No ☐ Unknown

Previous Cardiovascular Surgery: ☐ Yes ☐ No ☐ Unknown

Hematology/Blood Disorders: ☐ Yes ☐ No ☐ Unknown

Hypertension Requiring Medications: ☐ Yes ☐ No ☐ Unknown

Obesity: ☐ Yes ☐ No ☐ Unknown

Pulmonary Disease (COPD, Asthma): ☐ Yes ☐ No ☐ Unknown

Drug Abuse: ☐ Yes ☐ No ☐ Unknown

Neurological Disorders: ☐ Yes ☐ No ☐ Unknown

Neurological Disorders Detail: ☐ Multiple Sclerosis ☐ Neuropathic pain ☐ Stroke

Alcohol: ☐ Yes ☐ No ☐ Unknown

Alcohol Frequency: ☐ Rare (<1 drink per week) ☐ Occasional (>1 drink per week)
☐ Frequent (>1 drink per day)

Smoking: ☐ Yes ☐ No

Smoking Frequency: ☐ Rare (<1 time per month) ☐ Occasional (weekly)
☐ Frequent (daily)

Patient Signature: ______________________________ Date: ______________

Physician Signature: ______________________________ Date: ______________

Patient Name: ____ DOB: ________________

Gynecological History	Yes	No	
Menstruating			
Menses Regular			
Menses Irregular			
Cramping with Period			
Duration of period: ______ Days			
Need for Pain Medication (Please List):			
Birth Control Method:			

	Date
Age at first menses:	
If menopausal age at last menses:	

Obstetrical History	Date
How many pregnancies	
How many C-Section	
How Many Vaginal Deliveries	
Age when first Child born	