ASSOCIATES IN WOMEN'S HEALTH CARE

OBSTETRICS/GYNECOLOGY

DATE____________________

NAME____________________

Single ( ) Living Together (optional) ( )

BIRTHDATE____________________

Married ( ) Years Married____________

HEIGHT____________ WEIGHT____________

PARTNER'S NAME____________ AGE____

OCCUPATION____________________

Divorced ( ) Separated ( ) Widowed ( )

What do you consider your racial designation? Caucasian ( ) Black ( ) Hispanic ( ) Japanese/Chinese ( ) Korean ( ) South East Asian ( ) Filipino ( ) Native American ( ) Other ( )____________

Religious Preference (optional)____________________

What Physician referred you to our office?____________________

PRIMARY CARE PROVIDER____________________

MENSTRUAL HISTORY

- ____________Date last normal period began
- ____________Age at first menstrual period
- ____________How many days between the start of one period until the start of the next period.

Amount of flow Number of tampons per day________

Duration of flow ( ) 1-3 days ( ) 4-6 days ( ) 7 or more days

Cramps with period ( ) none/mild ( ) moderate ( ) severe

Premenstrual symptoms( ) none/mild ( ) moderate ( ) severe

Circle One

YES NO During the last 6 months have you had a period about once a month?

YES NO Have you had any bleeding between periods?

BIRTH CONTROL HISTORY (CIRCLE ALL THAT APPLY)

Diaphragm Cervical Cap Vaginal gels, foams

Condom Tubal Ligation Vaginal suppositories

Vasectomy (partner) Rhythym

Fertility Awareness Basal Body Temperature

Intrauterine device (type)____________________

When Inserted____________________

Birth Control Pills Years taken______ When did you stop______

Brand Names____________________

Are you currently using a method of birth control?____________

If yes, what method?____________

Have you had any problems with any method of birth control?

____

If yes, please explain____________________

PREGNANCY HISTORY

TOTAL NUMBER OF PREGNANCIES______

PRE TERM________ FULL TERM________ LIVING________

ABORTIONS________ STILLBIRTHS________

ECTOPIC (Tubal) PREGNANCIES________

MISCARRIAGES________ C-SECTIONS________

Number of children you have now____________________

Age at first pregnancy____________

Date last pregnancy ended____________

How? [ ] abortion [ ] miscarriage [ ] delivery

[ ] Yes [ ] No Are you planning to have a child / children in the future?

[ ] Yes [ ] No Do you think you could be pregnant now?

LIVE BIRTHS (COMPLETE IN ORDER OF DELIVERY)

#1 BORN (MO/YR)________ Sex____ Wt.______ Hrs in Labor________
Weeks early/late________ Epidural/anesthesia________
Hospital/City________________ Type of Delivery Vag / C-Sect
Complications____________________

#2BORN (MO/YR)________ Sex____ Wt______ Hrs in Labor________
Weeks early/late________ Epidural/anesthesia________
Hospital/City________________ Type of Delivery Vag / C-Sect
Complications____________________

#3BORN (MO/YR)________ Sex____ Wt______ Hrs in labor________
Weeks early/late________ Epidural/anesthesia________
Hospital/City________________ Type of Delivery Vag / C-Sect
Complications____________________

#4BORN (MO/YR)________ Sex____ Wt______ Hrs in labor________
Weeks early/late________ Epidural/anesthesia________
Hospital/City________________ Type of Delivery Vag / C-Sect
Complications____________________

***please list any complications such as birth defects, stillbirth, toxemia, diabetes, hemorrhage, infection, surgery, etc.*

PAST HISTORY

[ ] Yes [ ] No Do you think you are overweight?

[ ] Yes [ ] No Does your weight often fluctuate 10-15 pounds?

[ ] Yes [ ] No When dieting, do you starve yourself, make yourself vomit or take diuretics or laxatives to lose weight?

[ ] Yes [ ] No Do you eat in binges or eat huge amounts of food at one time?

[ ] Yes [ ] No Do you use seat belts?

[ ] Yes [ ] No ARE YOU ALLERGIC TO ANY MEDICATIONS?
IF YES, WHAT MEDICATIONS?____________________

[ ] Yes [ ] No [ ] Unsure Did you mother take DES while pregnant with you?

[ ] Yes [ ] No Do you smoke? How much? __________
____daily ____Weekly ____Monthly

[ ] Yes [ ] No Do you use caffeine products? How much? __________
____daily ____Weekly ____Monthly

[ ] Yes [ ] No Do you drink alcohol beverages? How much? __________
____daily ____Weekly ____Monthly

[ ] Yes [ ] No Do you, or have you ever used IV drugs?

[ ] Yes [ ] No Do you use recreational drugs?

SEXUAL HISTORY (This section is optional)

Age at first intercourse____________

Is your sexual preference: _____Heterosexual ____Homosexual ___Bisexual

[ ] Yes [ ] No Are you sexually active now?

[ ] Yes [ ] No Have you had more than one sexual partner in the past six months?

[ ] Yes [ ] No Have you ever had a pelvic exam?

[ ] Yes [ ] No Do you have any questions/concerns about sex you wish to discuss today?

[ ] Yes [ ] No At any time in your life have you been involved in a sexual act that was against your will or has been frightening or painful?

[ ] Yes [ ] No Are you in a relationship with a partner who physically hurts you (slaps, kicks, hits, pushes) or threatens you?

CURRENT AND RECENT MEDICATIONS: (include strength and frequency)

Prescription drugs:

____
____
____

Over-the-counter drugs:

____
____
____

FAMILY HISTORY

Were you adopted? [ ] Yes [ ] No

Have your blood relatives ever had any of the following?
If yes, who?

[ ] Yes [ ] No Diabetes?
[ ] Yes [ ] No Stroke?
[ ] Yes [ ] No Heart attack or heart disease?
[ ] Yes [ ] No High blood pressure?
[ ] Yes [ ] No Breast cancer?
[ ] Yes [ ] No Cancer of the cervix, uterus, ovary, colon, or pancreas?
[ ] Yes [ ] No Kidney disease?
[ ] Yes [ ] No Bleeding disorder?
[ ] Yes [ ] No Mental illness?
[ ] Yes [ ] No Did either parent die before age 50 from any of the above?

IMMUNIZATION RECORD

Please circle if immunized for any of the following (include date given if known)

__________Flu __________Hepatitis B
__________Tetanus __________Pneumovax

HOSPITALIZATIONS

List all hospitalizations and surgeries (except for pregnancy)

Year________ Reason________________________ Place________________ Anesthesia problems? [ ] Yes [ ] No

Year________ Reason________________________ Place________________ Anesthesia problems? [ ] Yes [ ] No

Year________ Reason________________________ Place________________ Anesthesia problems? [ ] Yes [ ] No

Year________ Reason________________________ Place________________ Anesthesia problems? [ ] Yes [ ] No

MEDICAL HISTORY

Have you had any of these? If yes (Y), give the year. Circle Y or N

Yes	No	Year		Yes	No	Year	
Y	N	_____	Visual problems (not glasses)	Y	N	_____	Uterine abnormalities
Y	N	_____	Epilepsy (seizures)	Y	N	_____	Diabetes or gestational diabetes
Y	N	_____	Migraine headaches (doctor-diagnosed)	Y	N	_____	Anemia
Y	N	_____	Stroke	Y	N	_____	Bleeding tendency
Y	N	_____	Thyroid disease	Y	N	_____	Varicose veins
Y	N	_____	Breast lump	Y	N	_____	Cancer / where? __________
Y	N	_____	Asthma / respiratory problems	Y	N	_____	Hepatitis / jaundice
Y	N	_____	Pulmonary embolus (blood clot)	Y	N	_____	Gall bladder disease
Y	N	_____	Lung disease	Y	N	_____	Mononucleosis
Y	N	_____	Kidney disease / infection	Y	N	_____	Rheumatic fever
Y	N	_____	3 or more bladder infections	Y	N	_____	Heart murmur
Y	N	_____	Heart disease	Y	N	_____	Blood clots in legs
Y	N	_____	Mitral prolapse	Y	N	_____	Drug abuse
Y	N	_____	High blood pressure	Y	N	_____	Alcohol abuse
Y	N	_____	High cholesterol / blood fats	Y	N	_____	Psychiatric problems
Y	N	_____	Obesity	Y	N	_____	Suicide attempts
Y	N	_____	Gastrointestinal disorder	Y	N	_____	Severe depression
Y	N	_____	Sickle cell trait or disease	Y	N	_____	Breast surgery
Y	N	_____	Genitourinary disorder	Y	N	_____	Tuberculosis
				Y	N	_____	Other major illness / What?

GYNECOLOGIC HISTORY

Date of last pap __________ Where taken__________ Result__________
Have you had any of these?

Yes	No	Year		Yes	No	Year	
Y	N	_____	Abnormal pap smear	Y	N	_____	Syphilis
Y	N	_____	Gynecologic surgery or procedure	Y	N	_____	Chlamydia
Y	N	_____	Pelvic tumor / fibroids	Y	N	_____	Herpes
Y	N	_____	Infected tubes or uterus (PID)	Y	N	_____	Genital warts
Y	N	_____	Frequent vaginal infections	Y	N	_____	Gonorrhea
Y	N	_____	Other female organ problems – Explain	Y	N	_____	Infertility
			______________________________	Y	N	_____	Trichomonas