Obstetrical and Gynecological Associates, PLLC

Date____________________Name____Age________

Reason for today's visit? Preventative or Problem Visit (please circle one)

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Gynecologic History:

Pregnancies_______Deliveries_______Miscarriages_______Abortions______Living children________

Last menstrual period _________Are periods regular?______ Any problems with periods?___________

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At what age did your periods begin?________________

Are you trying to get pregnant?____________________

Present type of contraception_______________ Do you want to change?______ To What?___________

Date of last Pap smear_________Results____

Y/N Have you ever had an abnormal pap or HPV test? Treatment?_____________________________

Date of last Mammogram________Results____

Y/N Have you ever had an abnormal mammogram or exam? Treatment?________________________

Y/N Have you had a bone densitometry? When?________ Results?___________________________

Y/N Have you had a colonoscopy? When?_________ Results?______________________________

Y/N Are you sexually active? Any difficulties or discomfort?_________________________________

Age at 1st intercourse________ Total number of sexual partners__________

Sexual preference: M / F / Both Number of current sexual partners________

Y/N Do you perform breast self exams? Any changes or concerns? ____________________________

Y/N Any vaginal discharge atypical for you? Itching?______________ Odor?__________________

Y/N Any bladder leakage? Explain____

Y/N Have you ever had any sexually transmitted infections? What?___________________________

(ex. Herpes, Gonorrhea, Chlamydia, Trichomonas, HIV, Hepatitis B or C, Syphilis, HPV)

Y/N Are you involved in an abusive relationship?____

Obstetrical History:

List pregnancies in chronological order:

Year	Sex	Baby's Weight	Hours in labor	Anesthesia	Vaginal or C-section	Complications	Child's name

Medications:

Drug allergies____

Medications list (include herbal and over-the-counter meds; include dosages for all)

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Surgical History: (include approximate date)

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Social History:

Occupation:_____________________ Marital status: single/ married _____# years/ divorced/ widowed

Y/N Do you smoke? How much?____

Y/N Do you drink alcohol? How much?_______________________________________

Y/N Do you use recreational drugs? Type & How much?_______________________________

Y/N Do you exercise? How much? ____

Medical History:

Have **YOU** been treated for any of the following medical conditions? (please circle)

Seizures / epilepsy	Hepatitis – Type ____	Skin problems
Stroke	Colon Problems	Lupus
Migraines	Intestinal disease	Cancer – Type ___________
Thyroid disease	Gallbladder disease	Blood clots
Heart problems	Kidney disease	Glaucoma
Heart attack	Kidney stones	High blood pressure
Asthma or pneumonia	Recurrent urinary infections	High cholesterol
Tuberculosis	Arthritis	Diabetes
Ulcers or reflux	Neurologic disease	Psychiatric problem

Please explain item above, or list other medical problems not listed:_____________________________

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Family History:

Is there a member of your immediate family with any of the following medical conditions?

Y/N Diabetes? Who?________________________________ Appx. age of onset_________________

Y/N Heart disease? Who?______________________________Appx. age of onset_________________

Y/N High Blood Pressure? Who?________________________Appx. age of onset_________________

Y/N High Cholesterol? Who?___________________________Appx. age of onset_________________

Y/N Osteoporosis? Who?______________________________Appx. age of onset_________________

Y/N Are you of Ashkenazi Jewish descent?

Please indicate any cancer diagnoses in your family:

Cancer Type	Yes	Relationship to you	Age at diagnosis	Living Y/N
Breast cancer				
Male breast cancer				
Multiple breast cancers in 1 individual				
Ovarian cancer				
Colon cancer				
Multiple colon cancers in 1 individual				
10 or more colon polyps in 1 individual				
Uterine (endometrial) cancer				
Stomach cancer				
Kidney / urinary tract cancer				
Brain cancer				
Small bowel cancer				
Billiary cancer				
Melanoma				
Pancreatic cancer				

List other significant medical problems or cancers in family members:

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Please provide name and number of all other treating physicians and their specialty:

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Do you allow us to discuss your results with them? Yes / No (circle one)

Signature________________________________