ASSOCIATES IN
Obstetrics & Gynecology

HISTORY FORM

Name: _____ Age: _____ Date: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____.

Current Medications you are taking: None
_____.
_____.
_____.

Allergies: None _____.
_____.
_____.
_____.

HISTORY OF PRESENT ILLNESS: New Problem Existing Problem (check all that apply)

- Excessive menstrual flow
- Pelvic pain or pressure feeling
- Bladder trouble, burning, frequency, blood in urine, control problems
- Bowel problems, bleeding, hemorrhoids, severe constipation
- Hot flashes or suspected menopausal symptoms
- Unusual vaginal discharge, itching or burning
- Spotting or bleeding between periods
- Other

GYNECOLOGICAL HISTORY:

Date of Last Menstrual Period: _____ Length of period in days: _____ # of days between cycles: _____.

Has there been any change in your menstrual cycle in the last six months? Yes No

Explain: _____.

Last Pap: ___/___/___ Normal Abnormal Previous history abnormal. Dexa Scan: ___/___/___.

Last Mammogram: ___/___/___ Normal Abnormal Previous history abnormal. Colonoscopy: ___/___/___.

REPRODUCTIVE HISTORY:

No. Miscarriages: _____

No. Pregnancies: _____ No. Deliveries: _____ No. Preterm Deliveries: _____ No. Terminations: _____ No. Living: _____.

Labor/Delivery Complications: ☐ Yes ☐ No Explain _____.

Contraception? Yes No Type: _____ ☐ Present ☐ Past ☐ Vasectomy ☐ Tubal Ligation

SEXUAL HISTORY:

Sexually Active: Yes No Age at 1st Intercourse: _____.

Length with current partner: _____. Total Lifetime Partners: _____.

PAST HISTORY:

Surgeries: _____.

Medical History/Health History: _____.

Immunizations: _____. Gardasil

FAMILY HISTORY:

Mother: Living Deceased, Cause _____ Father: Living Deceased, Cause _____.

Sibling: Number Living _____ Number deceased _____ Cause(s) _____.

Diabetes _____ High Blood Pressure _____ High Cholesterol _____.
Heart Disease _____ Breast Cancer _____ Colon Cancer _____.
Ovarian Cancer _____ Uterine Cancer _____ Other _____.

SOCIAL HISTORY:

Tobacco Use: Yes No _____. Seat Belt use: Yes No _____.
Alcohol: Yes No _____. Regular Exercise: Yes No _____.
Drug Use: Yes No _____. Domestic Violence: Yes No _____.

Marital Status Married Single Widowed Divorced

Number of Children living in the home _____. Number of people in household _____.

Current or most recent job _____.

Do you have any emotional or sexual problems to discuss confidentially with the doctor? Yes No

Review Of Systems

HISTORY INTAKE FORM
SIDE 2

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, OR OFTEN			
1. **CONSTITUTIONAL** Weight loss, or gain, fever or fatigue	**CURRENTLY**	**PAST**	**EXPLAIN**
2. **EYES** Double Vision, spots before eyes, or vision changes			
3. **ENT/MOUTH** Ear aches, ringing in ears, sinus problems, sore throat, mouth sores, or dental problems			
4. **CARDIOVASCULAR** Painful breathing, chest pain, difficult breathing on exertion, swelling of legs, or palpitations of heart			
5. **RESPIRATORY** Wheezing, spitting up blood, shortness of breath, chronic cough			
6. **GASTROINTESTINAL** Diarrhea, bloody stool, or constipation. Nausea/vomiting			
7. **GENITOURINARY** Blood in urine, urgency, frequency, Pain with urination, incomplete emptying, or stress incontinence. Abnormal periods, or painful intercourse			
8. **MUSCULOSKELETAL** Muscle weakness			
9. **SKIN/BREAST** Pain in breast, discharge, Masses, rash or ulcers			
10. **NEUROLOGICAL** Dizziness, seizures, numbness, trouble walking			
11. **PSYCHIATRIC** Depression or frequent crying			
12. **ENDOCRINE** Dry skin, abnormal thirst or hot flashes			
13. **HEMATOLOGIC/LYMPHATIC** Frequent bruises, cuts that do not stop bleeding, or enlarged lymph nodes			
14. **ALLERGIC/IMMUNOLOGIC** Allergies (list)			

NO COMPLAINTS

Patient Name _____ Date _____