SWEDISH COVENANT MEDICAL GROUP
Personal Health History Form
Obstetrics and Gynecology

PATIENT LABEL

PATIENT NAME: _____

PRIMARY DOCTOR: _____

REFERRED BY: _____

Reason for today's visit: _____

Medications:

Allergies:

PERSONAL INFORMATION:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Living with domestic partner

Current or most recent occupation: _____

GYNECOLOGICAL HISTORY:

First day of your last menstrual period: _____/_____/_____

Age of your first period: _____

Length of your period: _____ (Number of bleeding days) Number of days between each period: _____

Have you had any menstrual problems? No Yes If yes, explain: _____

Are you in a sexual relationship? No Yes

Are there any sexual problems? No Yes If yes, explain: _____

Sexual partners are: Men Women Both

Age at first intercourse: _____ Total number of sexual partners in your lifetime: _____

Method of birth control: Presently _____ In the Past _____

Date of your last Pap test: : _____/_____/_____

Results: Normal Abnormal (Please circle one) If abnormal, explain: _____

Have you ever had an abnormal Pap test? No Yes If yes, explain: _____

Date of last mammogram: _____/_____/_____ Any breast biopsies?: No Yes

Date of last bone scan: _____/_____/_____ Date of last flu shot: _____/_____/_____

Date of colonoscopy: _____/_____/_____ Did you receive the HPV vaccine? Yes No

OBSTETRIC HISTORY:

	Number		**Number**
Pregnancies		Miscarriages	
Full term births		Abortions	
Preterm births (< 37 weeks)		Ectopic/Tubal pregnancies	
Vaginal births		Living children	
Cesareans		Complications: No Yes, specify:	

MEDICAL HISTORY:

Illness	**No**	**Yes**	**Illness**	**No**	**Yes**
Diabetes			Heart disease		
High blood pressure			Stroke		
Sexually transmitted infections			Headaches/Migraines		
Osteoporosis/Bone disease			Seizures		
Thyroid disease			Asthma/Lung disease		

Illness	No	Yes	Illness	No	Yes
Urinary tract infections/Bladder problems			Kidney infections/Stones		
Blood clots in lungs or legs			Ulcers/Reflux		
Depression/Anxiety			Bowel Problems		
Cancer			Hepatitis/Liver disease		
Anemia			Other, specify:_____		

SURGICAL HISTORY: None ☐

Date	Surgery	Any Complications

SOCIAL HISTORY:

	No	Yes		
Tobacco: present or past use (circle)			Packs per day:	Years of use: Year Quit:
Alcohol			Drinks per day:	Drinks per week:
Drugs			Type of drug:	How used:
Diet/Herbal/Vitamin supplements			Type:	Dose:
Have you ever been sexually, physically or verbally abused? (Please circle)			By whom?	Currently?

FAMILY HISTORY: (e.g., mother, father, brother, sister, son, daughter)

	No	Yes	Relationship		No	Yes	Relationship
Breast cancer				Stroke			
Colon cancer				Heart disease			
Ovarian cancer				High blood pressure			
Uterine cancer				High cholesterol			
Other cancer, specify:				Birth defects or mental retardation			
Blood clots in legs or lungs				Alcoholism or drug abuse, specify:			
Osteoporosis				Dementia			
Diabetes				Other			

REVIEW OF SYSTEMS: (Please check if you are experiencing any of the following or add additional problems)

1. Constitutional	☐ Weight loss ☐ Weight gain ☐ Fatigue ☐ Fever ☐ Memory loss
2. Cardiovascular	☐ Chest pain ☐ Palpitations or irregular heartbeat ☐ Leg swelling
3. Respiratory	☐ Shortness of breath ☐ Cough ☐ Wheezing
4. Gastrointestinal	☐ Bloody stool ☐ Involuntary loss of gas or stool ☐ Heartburn ☐ Constipation
5. Genitourinary	☐ Frequency of urination ☐ Bloody Urine ☐ Painful urination ☐ Urgency to urinate ☐ Decreased libido ☐ Involuntary loss of urine ☐ Abnormal vaginal discharge ☐ Painful sex ☐ Pelvic pain ☐ Vaginal bulge ☐ Postmenopausal bleeding
6. Musculoskeletal	☐ Back pain ☐ Hip pain ☐ Painful joints
7. Skin	☐ Bruising ☐ Itching ☐ Rash ☐ Sores
8. Neurologic	☐ Dizziness ☐ Weakness ☐ Numbness ☐ Tremors
9. Psychiatric	☐ Anxiety ☐ Depression ☐ Suicidal thoughts ☐ Homicidal thoughts
10. Endocrine	☐ Hot Flashes ☐ Breast tenderness ☐ Night sweats

Patient Signature_____ Date__/__/____ Physician Signature_____ Date__/__/____