OB/GYN HEALTH PARTNERS
PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth____/____/____ Today's Date_____
〔Single 〔Married 〔Separated 〔Divorced 〔Widowed Referred By_____

Medical History Have you ever had any of the following?

❑ Anemia	❑ Blood Clots in Lungs/Legs	❑ Chicken Pox	❑ Pneumonia
❑ Heart Disease/Attack	❑ Gall Bladder Disease	❑ Epilepsy/Seizures	❑ Tuberculosis
❑ High Blood Pressure	❑ Liver Disease/Hepatitis	❑ Migraines	❑ Sickle Cell Disease
❑ Stroke	❑ Kidney Infections	❑ Depression/Anxiety	❑ Thyroid Problem
❑ High Cholesterol	❑ Bladder Infections	❑ Drug or Alcohol Problem	❑ Blood Transfusion
❑ Mitral Valve Prolapse	❑ Pelvic Infections	❑ Diabetes	❑ Genetic Condition
❑ Bleeding Problems	❑ Arthritis	❑ Asthma	❑ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____ _____
_____ _____ _____ _____

List any allergies to medications: _____ 〔No Known Allergies

Surgical History Please list all surgeries with dates:

_____ _____
_____ _____

Obstetrical History

〔Check here if you have never been pregnant 〔Check here if you have adopted children and list names below
Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gyn History

Age of first period _____
Age of last period _____
Cycle length: every _____ days
lasting _____ days

Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Not really bothersome

Flow is: ❑ Light ❑ Light to moderate ❑ Moderate to heavy ❑ Very heavy

Are you sexually active? ❑ Yes ❑ No ❑ virginal

Sexual preference: ❑ heterosexual ❑ homosexual ❑ bisexual

New partners? 〔yes 〔no
Number of lifetime partners _____

Method of Birth Control: ❑ condoms ❑ pills ❑ patch ❑ vaginal ring ❑ tubal/Essure ❑ IUD ❑ partner with vasectomy ❑ natural family planning ❑ other ❑ none

Have you ever had any of the following STDs? ❑ Chlamydia ❑ Gonorrhea ❑ Herpes ❑ HPV ❑ Syphilis ❑ Trichomonas ❑ HIV ❑ Hepatitis B ❑ Hepatitis C ❑ Never had any

Have you ever had any of the following? ❑ Fibrocystic breasts ❑ Ovarian cysts ❑ Endometriosis ❑ Uterine fibroids

Date of last pap smear_____ 〔normal 〔abnormal
Have you ever needed any of the following for an abnormal pap? ❑ Colposcopy ❑ LEEP/Laser/Conization ❑ Cryosurgery ❑ No

Date of last mammogram _____ ❑ Normal ❑ Abnormal ❑ Never had one
Date of last bone density _____ ❑ Normal ❑ Osteopenia ❑ Osteoporosis ❑ Never had one
Date of last colonoscopy_____ Never had one

Family History

Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative
❑ Breast cancer		❑ High blood pressure	
❑ Ovarian cancer		❑ Diabetes	
❑ Uterine cancer		❑ Heart Disease (heart attack,	
❑ Colon cancer		stroke, bypass surgery)	

Social History

Alcohol use	❑ Yes	❑ No	If yes, _____drink(s) per day/week/month
Tobacco use	❑ Yes	❑ No	If yes, _____ pack(s) per day for _____ years
Street drug use	❑ Yes	❑ No	Type and frequency_____
Exercise	❑ Yes	❑ No	Type and frequency_____
Caffeine	❑ Yes	❑ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week
Sexual Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑yes ❑no Counseling? ❑yes ❑no
Physical Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑yes ❑no Counseling? ❑yes ❑no
Emotional Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑yes ❑no Counseling? ❑yes ❑no

Review of Systems Do you currently have any of the following?

	Comments
❑Y ❑N Generally healthy	
❑Y ❑N Recent weight gain or loss of 25 lbs.	
❑Y ❑N Fever	
❑Y ❑N Vision problems (excluding glasses)	
❑Y ❑N Sinus problems	
❑Y ❑N Hearing loss	
❑Y ❑N Chest pain	
❑Y ❑N Varicose veins	
❑Y ❑N Shortness of breath	
❑Y ❑N Chronic cough	
❑Y ❑N Diarrhea	
❑Y ❑N Constipation	
❑Y ❑N Blood in stools	
❑Y ❑N Heartburn/reflux	
❑None of the above	

	Comments
❑Y ❑N Frequent urination	
❑Y ❑N Burning with urination	
❑Y ❑N Incontinence	
❑Y ❑N Urgency	
❑Y ❑N Bladder infection	
❑Y ❑N Stomach pains	
❑Y ❑N Vaginal discharge	
❑Y ❑N Irregular vaginal bleeding	
❑Y ❑N Pelvic pain	
❑Y ❑N Painful intercourse	
❑Y ❑N Breast lumps	
❑Y ❑N Back pain	
❑Y ❑N Joint/muscle pain	
❑Y ❑N Depression/anxiety	
❑ None of the above	

Patient Signature_____ Date_____

Clinician Signature_____ Date_____

Annual Review #2 Clinician Signature_____ Date_____

Annual Review #3 Clinician Signature_____ Date_____