OB / GYN HISTORY FORM CHART #_____

Name:	Date of Birth:	Age:	Date:

PAST MEDICAL HISTORY

	Yes	No	Date			Yes	No	Date
Anemia					Elevated cholesterol			
Asthma					Hypercoagulation Syndrome			
Hospitalized for Asthma					Hypertension (High blood pressure)			
Breast Cancer					Hyperthyroidism			
Breast Cyst, Benign					Hypothyroidism			
Chickenpox					Irritable Bowel Syndrome			
Cholelithiasis (Gall Stones)					Kidney Calculus/Stone			
Coronary Artery Disease					Migraine			
Deep Vein Thrombosis					Mitral Valve Prolapse			
Depression					Osteopenia			
Diabetes Mellitus					Osteoporosis			
Diverticulosis of Colon					Peptic Ulcer Disease			
Emphysema					Previous Blood Transfusion			
Epilepsy					Why transfused?			
Fibrocystic Changes of Breast					Pulmonary Embolism			
Glaucoma					Sickle Cell Anemia			
Hepatitis					Tuberculosis			
Human Immunodeficiency Virus (HIV)					Urinary Tract Infection (UTI)			
OTHER:					OTHER:			

PAST SURGICAL HISTORY

	List Surgery	Date

ALLERGIES/REACTION

	Allergy to:	Reaction caused:

GYNECOLOGIC HISTORY

			Date				Date
Yes	No	Abnormal Pap Smear		Yes	No	Any Sexually Transmitted Disesases?	
Yes	No	Abnormal Bleeding/Irregular Bleeding				If yes, type:	
Yes	No	Endometriosis					
		If yes, how was it diagnosed?		Yes	No	Pelvic Inflammatory Disease	
		Other:				If yes, type:	

MENSTRUAL HISTORY

Age Started Period:	
Last Menstrual period:	
How often : How long:	
Birth control method:	
Menopause? Yes No If yes, at what age?_____	

PREGNANCY HISTORY

Total Number of pregnancies:	
# of Full Term	# of Premature
# of Miscarriages	# of Abortions
Type of Delivery(s) Weight	Date
If Cesarean please give reason:	
Any other problems during pregnancy?	

SOCIAL HISTORY

Smoke If yes, _____pk/day for _____years	Yes	No

FAMILY MEDICAL HISTORY

			Relative/Age
Breast Cancer	Yes	No	

Drink Alcohol If yes, _____oz/day for _____years	Yes	No	Colon Cancer	Yes	No	
Any Drug Use If yes, then type_____	Yes	No	Diabetes	Yes	No	
Caffeine	Yes	No	Heart Disease	Yes	No	
Wear Seat Belt	Yes	No	High Blood Pressure	Yes	No	
Get Calcium In Diet	Yes	No	High Cholesterol	Yes	No	
Exercise	Yes	No	Osteoporosis	Yes	No	
Domestic Violence(Past or Present)	Yes	No	Ovarian Cancer	Yes	No	
Married	Yes	No	Stroke	Yes	No	
Adopted	Yes	No	Thyroid Disease	Yes	No	
Occupation:			**OTHER:**			

SCREENING TESTS			**Date**	**Result**		**SCREENING TESTS**			**Date**	**Result**
Colonoscopy	Yes	No				Mammogram	Yes	No		
Dexa Scan	Yes	No				Pap Smear	Yes	No		

VACCINES (Are you up to date on the following vaccinations?)

Hepatitis A	**Yes**	**No**	**MMR/Rubella**	**Yes**	**No**
Hepatitis B	**Yes**	**No**	**Seasonal Flu**	**Yes**	**No**
HPV	**Yes**	**No**	**Tetanus, Diptheria, Pertussis**	**Yes**	**No**

MEDICATIONS (Prescriptions, Vitamins, Herbal/Alternative Meds)

Current Medication:	Dosage	Indication	Prescribed by:

Please feel free to write down anything we may not have asked that you feel is important to include in your chart.

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