MRN#

OB/GYN History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Primary Care Physician: _____ **Referring Physician:** _____

MENSTRUAL HISTORY / SYSTEM REVIEW

Menstrual flow is usually: heavy ○ moderate ○ light ○

How many days do you usually bleed? _____ How many days are in-between bleeding? _____

Pain with periods is: mild ○ moderate ○ severe ○

PMS symptoms:	yes ○	no ○	Pain with a full bladder:	yes ○	no ○
Severe cramps:	yes ○	no ○	Are you on hormone replacement?	yes ○	no ○
Pain / bleeding during / after sex:	yes ○	no ○	Difficulties controlling urine:	yes ○	no ○
Bleeding since period stopped:	yes ○	no ○	Problem with / interest / enjoy sex:	yes ○	no ○

If you had an abnormal pap smear, how treated? _____

Do you have menopausal symptoms? yes ○ no ○ Please specify: _____

PERSONAL MEDICAL HISTORY

○ **NO MEDICAL HISTORY**

Please indicate if YOU have a history of the following:
Mark all that apply. If none, mark, "**NO MEDICAL HISTORY**."

PAST	CURRENT		PAST	CURRENT	
○	○	Broken Hip	○	○	Measles
○	○	Broken Wrist	○	○	Mononucleosis
○	○	Chicken Pox	○	○	Mumps
○	○	Chlamydia	○	○	Ovarian Cancer
○	○	Eating Disorder	○	○	Polio
○	○	Fibroids - Uterine	○	○	Rh Sensitized
○	○	Gardnerella	○	○	Scarlet Fever
○	○	Genital Warts	○	○	Syphilis
○	○	Gonorrhea	○	○	Trichomonas
○	○	Height Loss	○	○	Typhoid Fever
○	○	Herpes - Genital	○	○	Vaginal Yeast Infections
○	○	Infertility	○	○	Varicose Veins

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following:

○ **Family History UNKNOWN** ○ **ADOPTED** ○ **No Past Family Medical History**

Please indicate which family member(s) have had these illnesses:	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Birth Defects	○	○	○	○	○	○	○	○
Cystic Fibrosis	○	○	○	○	○	○	○	○
Mental Retardation	○	○	○	○	○	○	○	○
Sickle Cell Anemia	○	○	○	○	○	○	○	○
Ovarian Cancer		○	○		○			○

SOCIAL HISTORY

Have you ever been or felt threatened by your husband / partner?	yes ○	no ○
Are you exposed to any hazardous substances at your job?	yes ○	no ○
Do you perform heavy lifting for your job?	yes ○	no ○
Are you experiencing any stress on your job?	yes ○	no ○
Are you experiencing any life stress?	yes ○	no ○