NGYN

OB/GYN associates

OB-GYN Associates - Medical History Form - New GYN and New OB Patients

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

Name:_____ Date:_____

Birthdate:_____ Age:_____

Primary Care Physician:_____ Preferred Lab:_____

Preferred Pharmacy:_____ Preferred Imaging Center:_____

Reason for Visit: Please check

☐ Annual - Well Woman Exam Check Up

☐ Problem - Please List:_____

Gynecology (Female) History:

First day of most recent period:_____

Age of first period:_____

Number of days between each period:_____

How many days do periods last?_____

Cramping: none mild medium strong severe

Flow: none light medium heavy clots

Pregnancy History:

Number of times pregnant:_____

Number of miscarriages:_____

Number of abortions:_____

Number of premature births:_____

Number of on-time births:_____

Number of living children:_____

Current Contraception: (Please indicate)

☐abstinence ☐withdrawal ☐rhythm ☐condoms ☐foam/spermicides ☐pills

☐patch ☐ring ☐depo-provera ☐implant ☐tubes tied/plugged ☐IUD

☐vasectomy ☐hysterectomy ☐infertility ☐menopause ☐same gender sexual partner ☐none

Have you gone through Menopause? **Yes** **No** **Currently**

Have you ever used Hormone Therapy? **Yes** **No** **Currently**

Gynecology (female) Problems (past and present): Please circle all that apply:

____ Abnormal pap smear
____ Cervical Cancer
____ Cervical Dysplasia (pre-cancer)
____ Laser/LEEP/Freezing of Cervix
____ HPV
____ Endometriosis
____ Laparoscopy
____ Cesarean Section
____ Sterilization (tubes tied/ tubal plugs)
____ Bladder "lift/sling"
____ Hysterectomy
____ Endometrial (uterine) ablation
____ Genital Herpes
____ Chlamydia
____ Gonorrhea

Pregnancy History

Date	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Pre Term Labor	Comments / Complications

Health Maintenance and Modifiers:

Please list dates of last test, treatment, or vaccine:

Pap Smear: _____ Colonoscopy: _____

Mammogram: _____ Cholesterol/Lipid Screen: _____

Bone Density: _____ Gardasil/HPV Vaccine: _____

Genetic Testing (cancer or carrier?): _____ Flu Vaccine: _____

COVID-19 Vaccine: _____ Chicken Pox Vaccine: _____

Exercise: ☐none ☐irregular ☐regular ☐aerobic ☐weight bearing

Calcium: ☐none ☐milk/dairy ☐dietary ☐supplements

Sexual Activity:

Have you **ever** been in a sexual relationship?:	☐**Yes**	☐**No**	
Are you currently in a sexual relationship?	☐**Yes**	☐**No**	
New sexual partner in last year?	☐**Yes**	☐**No**	
Current sexual partner:	☐**Male**	☐**Female**	
Prevention of Sexually Transmitted Infection:	☐**Abstinence**	☐**Condoms**	☐**Monogamy**
Do you want testing for STIs?	☐**Yes**	☐**No**	
Safety: Is violence at home a concern for you?	☐**Yes**	☐**No**	
Have you ever been abused?	☐**Yes**	☐**No**	

Personal Past Medical History:

No Medical Problems	☐				
Asthma	**Yes**	**No**	High Blood Pressure	**Yes**	**No**
Anemia	**Yes**	**No**	High Cholesterol	**Yes**	**No**
Blood Clotting Disorder	**Yes**	**No**	Intestinal Problems	**Yes**	**No**
Breast Problems	**Yes**	**No**	Kidney Problems	**Yes**	**No**
Cancer	**Yes**	**No**	Liver Disease	**Yes**	**No**
Depression	**Yes**	**No**	Migraine	**Yes**	**No**
Diabetes	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Gall Bladder Problems	**Yes**	**No**	Stomach Problems	**Yes**	**No**
Heart Problems	**Yes**	**No**	Stroke	**Yes**	**No**
			Thyroid Problems	**Yes**	**No**

Other Problems/Further Details _____

_____

Past Surgical History: Please list ALL surgical procedures and ages or dates

Year / Age	Type of Surgery

Allergies: (to medications, latex, iodine, shellfish, or nuts)

Allergy	Reaction Type

Medications: (Name, dose and prescribing doctor)

Medication Name	Dosage	Frequency	Prescribing Doctor

Supplements: Supplements, Vitamins, etc

Supplement	Reason for use

Social:

Your Occupation:_____

Your Employer:_____

Marital Status: single engaged domestic partner married separated divorced widowed

Name of spouse/partner:_____

Alcohol: Average number of drinks _____/day or _____/week or none

Any concern about personal alcohol misuse or abuse? Yes No

Tobacco: Do you smoke?: ☐Yes ☐No ☐Past

If yes, how many cigarettes per day? _____ for how long? _____

Quit date _____

Recreational Drug Use: ☐Yes ☐No ☐Past

Family History:			**List Family Member (parent, grandparent, sibling, aunt, uncle, children)**
Bleeding Tendency	Yes	No	_____
Blood Clotting Disorder(s)	Yes	No	_____
Diabetes	Yes	No	_____
Breast Cancer	Yes	No	_____
Ovary Cancer	Yes	No	_____
Colon Cancer	Yes	No	_____
Other Cancer	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
High Cholesterol	Yes	No	_____
Stroke	Yes	No	_____
Kidney Problems	Yes	No	_____
Osteoporosis	Yes	No	_____
Mental Illness	Yes	No	_____

Patient Signature / Date:_____