

Ob-Gyn Physicians, Inc.

A Division of Mid-Atlantic Women's Care, P.L.C.

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Health History Form

Please fill in all information below

Name: _____ Date: _____ Referred by: _____

Reason for visit: _____

I Menstrual History

(If you are menopausal or have had a hysterectomy, skip to part III)

First day of most recent period (date) _____

How many days between starts of periods _____

How long do your periods last _____

Any problems with your periods? No Yes

Describe if yes _____

II Contraceptive History

Current contraception (include tubal or vasectomy) _____

Name of birth control pill _____

Any problems with current method _____

Other past methods used _____

III Pregnancy History

____ Total pregnancies

____ Miscarriages

____ Abortions

____ Vaginal deliveries

____ Caesarian sections

Describe any serious problems with pregnancies _____

Are you currently trying to get pregnant No Yes

V Gyn History

Have you had any of the following (check below)

abnormal Pap smear

cervical cryo or laser surgery

condyloma/genital warts

endometriosis

ovarian cysts/tumors

uterine fibroids

pelvic inflammatory disease

other GYN problems

Describe above _____

Date of last Pap test _____ Last pelvic _____

Date of last mammogram (if over 35) _____

List relatives with breast or ovarian cancer _____

VI Current Medications (list):

VII Allergies (list) :

IV Past Medical History

Describe or enter comments

Anemia/blood disorders Self Family _____

Birth defects Self Family _____

Blood transfusions Self Family _____

Bowel disorders Self Family _____

Breast disease Self Family _____

Cancer/type Self Family _____

Diabetes Self Family _____

Epilepsy/Neurological Self Family _____

Gallbladder disease Self Family _____

Hypertension Self Family _____

Jaundice/Hepatitis Self Family _____

Kidney problems Self Family _____

Migraines/Severe headaches Self Family _____

Musculoskeletal problems Self Family _____

Phlebitis/Thrombosis Self Family _____

Respiratory problems Self Family _____

Thyroid disease Self Family _____

Urinary tract disease Self Family _____

Smoking/Cigs per day Self _____

Other Self Family _____

VIII Surgeries/Hospitalization (list):

_____ date _____

_____ date _____

_____ date _____

_____ date _____