Ob-Gyn Physicians, Inc.
A Division of Mid-Atlantic Women's Care, P.L.C.
J. Floyd Clingenpeel, MD
Sharon Sheffield, MD, FACOG
Tobi W. Byrd, WHNP, CNM

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

Condition	Self	Family	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 ________