**Ob-Gyn Physicians, Inc.**
A Division of Mid-Atlantic Women's Care, P.L.C.

# 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 _____