CENTRAL CAROLINA OB/GYN HEALTH HISTORY FORM

Division of Piedmont Healthcare for Women, P.A.

DATE_____

Name_____ ID #_____ DOB _____

Allergies_____

Religion_____ Ethnicity/Race_____

Occupation_____

Who is your medical or family doctor?_____

Problems or concerns?

_____

_____

_____

How long has this been a problem?_____

What have you tried for this?_____

Did it help?_____

WOMAN'S HEALTH HISTORY

A. Menstrual cycle:

Age at first period?_____ How often are your periods?_____

How long do your periods last?_____

What was the first day of your last period?_____

Any problems with your period? Such as: very heavy flow, irregular periods, bleeding between your periods, bad cramps, other – please list_____

_____

B. Sexual History:

Sexual preference? Male_____ Female_____

Number of sexual partners in your lifetime? (circle) 0-2 3-5 >5

Are you currently sexually active?_____

C. Pap Smears:

Have you ever had an abnormal Pap smear?_____ If so, when?_____

What was done for it?_____

When was your last Pap smear?_____ Was it normal?_____

D. Gyn Infections/Surgeries:

Have you ever had any of the following?

Yeast_____
Bacterial_____
Trichomonas_____
Chlamydia_____
Gonorrhea_____
Warts (HPV)_____
Herpes_____
Syphillis_____

D & C_____
Laparoscopy_____
C-section_____
Myomectomy_____
Hysterectomy_____
Tubes tied_____
Ectopic or tubal pregnancy_____
Ovarian cyst_____
Other_____

E. Birth Control:

What are you using for birth control? Circle all that apply.

Abstinence Condoms Female condom Diaphragm IUD Contraceptive film

Spermicidal foam Spermicidal jelly Norplant DepoProvera Birth control Pills

Bilateral tubal ligation Vasectomy Withdrawal

Are you satisfied with your current method?_____

If you stopped using birth control in order to get pregnant, when did you stop?_____

F. Other GYN or female problems:

Breast lumps?_____
Have you ever had a Mammogram? _____ When was your last one?_____ Results?_____
Do you have discharge from your breasts?_____

Fibroids?_____

Abnormalities of uterus or cervix?_____

Pain with intercourse?_____

Did your mother take DES when pregnant with you?_____

Infertility?_____ If so, what if any treatment?_____

G. Pregnancy History

How many times have you been pregnant?_____How many living children do you have?_____

How many fullterm deliveries?_____ How many preterm deliveries?_____

How many miscarriages?_____ How many abortions? _____

How many if any stillbirths?_____ Any twins? _____

Any problems with previous pregnancies such as the following?

Low iron diabetes of pregnancy heavy bleeding vomiting severely

Incompetant cervix too much or too little water around your baby

Depression after delivery high blood pressure during pregnancy preterm labor

Rh negative blood Group B Strep

Other (please list)_____

H. Preconceptual/Genetic History

Have you or your partner or either of your families had any of the following?

Cerebral Palsy_____ Cleft lip or Palate_____
Birth defects_____ Heart defects_____
Cystic fibrosis_____ Downs syndrome_____
Hemophilia_____ Huntington's Chorea_____
Mental retardation_____ Muscular dystrophy_____
Spina Bifida or NTD's_____ Sickle cell trait or disease_____
Tay Sach's Disease_____ Test for Fragile X_____
Thalassemia A or B _____
Are you in any way blood related to your partner?_____
Other_____

Partner's ethnic background?_____
Partner's age_____

Environmental risks:

Do you have cat?_____

Any chemical exposures?_____

Do you smoke?_____ If so, how much?_____ For how long?_____

Any second-hand smoke exposure?_____

Do you drink any alcoholic beverages?(beer, wine, wine-coolers, liquor etc)_____

If yes, how much in a week on average?_____

Any other recreational drug use?_____

I. General Medical History

Have you or any of your close blood relatives had any of the following?

	Pt	Family		Pt	Family
Heart disease	_____	_____	Rheumatic fever	____	_____
Mitral valve prolapse	____	_____	High blood pressure	____	_____
Varicose veins	___	_____	Blood clots	____	_____
Bleeding disorders	___	_____	Low iron	____	_____
Sickle cell trait	___	_____	Blood transfusion	____	_____
Asthma	___	_____	Tuberculosis	____	_____
Emphysema	___	_____	Diabetes	____	_____
Thyroid Disease	___	_____	Bladder infections	____	_____
Kidney infections	___	_____	Kidney problems	____	_____
Leaking of urine	___	_____	Seizures	____	_____
Epilepsy	___	_____	Migraines	____	_____
Frequent headaches	___	_____	Strokes	____	_____
Cancer	___	_____	Mental/emotional probs	____	_____
Intestinal problems (hernia, irritable bowel, ulcers, Crohn's disease, etc)	___	_____	Liver problems (cirrhosis, hepatitis,etc)	____	_____
			Scoliosis	____	_____
Auto immune disease (sarcoidosis, lupus, rheumatoid arthritis, etc.)	___	_____	Joint problems	____	_____

Have you ever had any of the following?

Chicken pox?_____ Measles?_____
Mumps?_____ Rubella?_____
HIV?_____

Do you have any of the following?

Vision problems(do you wear glasses or contact lenses?)_____
Hearing problems?_____
Dental problems?_____

Have you ever been the victim of emotional or physical abuse in the past or currently?_____

Have you ever had any major accidents(broken bones, auto accidents, etc)?_____

Any surgeries(wisdom teeth, appendix, tonsils etc)? Please list_____

_____

Any anesthesia problems?_____

What medications if any do you take regularly?_____

_____

J. Lifestyle:
Exercise – Regular – Occasional – Rare Self Breast Exams – monthly – occasional – rare
Diet: Regular - Vegetarian. If vegetarian, what kind of vegetarian_____