

| **HEALTH HISTORY FORM -** *Obstetrics & Gynecology appts* |
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**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Chart#:** \_\_\_\_\_\_\_\_\_\_

* **GYN History:**  What was the first day of your last menstrual period? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

1. What method were you using to prevent pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many days do you normally flow during your cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How often are your periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have painful periods?...................................................................................................... 𞠡Yes 𞠡No
5. Do you have bleeding between periods? …………………………………………………………….𞠡Yes 𞠡No
6. How old were you when you had your first period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you have a history of abnormal Pap smears requiring treatment?........................................ 𞠡Yes 𞠡No
8. If yes, what type of treatment have you had?

𞠡Cryo therapy, year: \_\_\_\_\_ 𞠡Laser,year: \_\_\_\_\_

𞠡Cone biopsy, year: \_\_\_\_\_ 𞠡Loop excision (LEEP), year: \_\_\_\_\_

10. Other Gyn History: Check any that apply, or 𞠡NONE.

𞠡Chlamydia 𞠡Herpes, genital 𞠡Syphilis 𞠡Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𞠡Endometriosis 𞠡HPV 𞠡Vaginal Infections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

𞠡Gonorrhea 𞠡Pelvic Inflammatory disease 𞠡Veneral Warts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Medical History:**

1. List any prescription medications, over the counter medications or herbs you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List any **MEDICATION ALLERGIES**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. List any **OTHER Allergies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Are you being treated for any illness, condition or surgery by another physician? 𞠡Yes 𞠡No

If so, which physician and for what reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**➕ Social History:**

1. Marital Status: 𞠡Single 𞠡Married 𞠡Separated 𞠡Long Term Relationship 𞠡Divorced 𞠡Widowed
2. Smoking: 𞠡Never 𞠡Former 𞠡Current, Packs per Day: \_\_\_\_\_\_\_ 𞠡Years Smoked: \_\_\_\_\_\_\_\_

𞠡Year Quit Smoking: \_\_\_\_\_ 𞠡Cigarettes 𞠡VAPE 𞠡Hooka 𞠡Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you drink alcohol? 𞠡Yes 𞠡No…..If YES, Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you use any illegal/illicit drugs? 𞠡Never 𞠡Occasional 𞠡Daily 𞠡Prior Use - Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Drug Abuse: (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Caffeine Intake: 𞠡None 𞠡Coffee 𞠡Tea 𞠡Soda 𞠡Energy Drink 𞠡Chocolate

Daily Intake:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a concern about sexually transmitted diseases or testing? 𞠡Yes 𞠡No
2. Are you or any other member of your family in an abusive situation? 𞠡Yes 𞠡No
3. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Exercise type/frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**➕ Obstetrical History:** 𞠡 I have never been pregnant before > *Skip to Past Medical History section.*

1. How many pregnancies have you had?
2. How many were: Full term \_\_\_\_\_\_\_\_, Premature \_\_\_\_\_\_\_\_, Miscarriages \_\_\_\_\_\_\_\_, Abortions \_\_\_\_\_\_\_\_?
3. Please list each pregnancy. Please include any miscarriages and/or abortions.

| **#** | **Year** | **Place** | **Duration of Gestation** | **Anesthesia** | **Duration of Labor** | **Type of Delivery** | **Weight** | **Sex of Baby** | **Complications**  **Maternal** | **Complications Infant** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1st |  |  |  |  |  |  |  |  |  |  |
| 2nd |  |  |  |  |  |  |  |  |  |  |
| 3rd |  |  |  |  |  |  |  |  |  |  |
| 4th |  |  |  |  |  |  |  |  |  |  |

**➕ Past Medical History:** What is your usual weight? What is your usual height?

1. Have you ever had a blood transfusion? 𞠡Yes 𞠡No…..If YES, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please list all Non-Obstetrical hospitalizations, surgeries or outpatient surgeries:

| **Date** | **Place** | **Reason** | **Doctor** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Have YOU ever had any of the following?

Blood Clots in your legs or lungs 𞠡Yes 𞠡No Kidney or Bladder problems 𞠡Yes 𞠡No

Blood Diseases 𞠡Yes 𞠡No Lung Disease / Asthma 𞠡Yes 𞠡No

Cancer (what type?) 𞠡Yes 𞠡No Mental Problems or Depression 𞠡Yes 𞠡No

Chicken Pox 𞠡Yes 𞠡No Migraines 𞠡Yes 𞠡No

Diabetes 𞠡Yes 𞠡No Seizures 𞠡Yes 𞠡No

Heart Disease / Heart Problems 𞠡Yes 𞠡No Sexually Transmitted Diseases 𞠡Yes 𞠡No

High Blood Pressure or Stroke 𞠡Yes 𞠡No Thyroid Disease 𞠡Yes 𞠡No

High Cholesterol 𞠡Yes 𞠡No

**➕ Family History:**

Please circle **Yes** to those that apply to **YOUR FAMILY**: (on both YOUR **mother’s or father’s side -** such as children,

parents, grandparents, sisters, brothers, aunts, uncles, nieces, nephews)

* Cancer ………………………………………………………………………………………………………. 𞠡Yes 𞠡No

(If so, what type?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Heart Disease or Heart problems that occurred before the age of 55?............................................ 𞠡Yes 𞠡No
* Diabetes……………………………………………………………………………………………………… 𞠡Yes 𞠡No
* High Blood Pressure or Stroke……………………………………………………………………………. 𞠡Yes 𞠡No
* Endometriosis………………………………………………………………………………………………. 𞠡Yes 𞠡No
* Any other Major Medical problems……………………………………………………………………….. 𞠡Yes 𞠡No

**CHECK YOUR PATIENT PORTAL TO REQUEST FUTURE PRESCRIPTION**

**REFILLS, CHECK LAB RESULTS & MORE!**

| **Signature *(Patient/Parent/Legal Guardian)*** |  |
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4551 New Bern Avenue, Ste. 160 | 3350 Six Forks Rd |Raleigh, NC | ph: 919.556.1008 | fax: 919.556.6099