Desert Sage
Obstetrics and Gynecology

OB / GYN HISTORY FORM

Name	Date of Birth	Age	Date

With whom may we discuss test results or therapies?_____ At what phone number can we leave a secured voice mail? _____

Past Obstetrical History - To include miscarriages, ectopics and abortions.

Date (Mo. /Yr.)	1	2	3	4	5	6
Birth Weight						
Type of delivery (Vaginal/C-sect.)						
Complications						

Are you done having children? ☐ Yes ☐ No

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Last menstrual period	Contraception
Duration of flow	Partner has had Vasectomy? ☐ Yes ☐ No
Cramps? Mild / Mod / Severe / None	Age at Menopause
Time between periods	Bone Density ☐ Yes - when_____, ☐ No

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ HIV ☐ Trichamonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Other

Allergies - List Reaction	**Medications & Dosage -** Include Vitamins / Herbs

CONTINUE ON BACK SIDE

_____ _____
Reviewed by (Signature of Provider) Date

Past Medical History

Patient's Name _____

Diabetes ☐ Yes ☐ No Comments	Kidney Disease ☐ Yes ☐ No Comments	Blood Clots Leg/Lung ☐ Yes ☐ No Comments
High Blood Pressure ☐ Yes ☐ No Comments	Urinary Tract Infections ☐ Yes ☐ No Comments	Neurologic/Epilepsy ☐ Yes ☐ No Comments
Heart Disease ☐ Yes ☐ No Comments	Thyroid Dysfunction ☐ Yes ☐ No Comments	Gastrointestinal ☐ Yes ☐ No Comments
Rheumatic Fever ☐ Yes ☐ No Comments	Tuberculosis ☐ Yes ☐ No Comments	Hepatitis/Liver Disease ☐ Yes ☐ No Comments
Mitral Valve Prolapse ☐ Yes ☐ No Comments	Asthma ☐ Yes ☐ No Comments	In Utero DES ☐ Yes ☐ No Comments
Psychiatric ☐ Yes ☐ No Comments	Anesthesia Complications ☐ Yes ☐ No Comments	Other ☐ Yes ☐ No Comments

Immunization History

Have you been vaccinated against Hepatitis B? ☐ Yes ☐ No If yes, when? _____
Have you been vaccinated against Influenza? ☐ Yes ☐ No If yes, when? _____
Have you been vaccinated against Pneumonia? ☐ Yes ☐ No If yes, when? _____
Have you been vaccinated against Tetanus? ☐ Yes ☐ No If yes, when? _____
Have you had chicken pox? ☐ Yes ☐ No If no, have you been vaccinated? ☐ Yes ☐ No
Have you had Rubella (German Measles)? ☐ Yes ☐ No If no, have you been vaccinated? ☐ Yes ☐ No
Have you had a PPD skin test? ☐ Yes ☐ No If yes, ☐ positive or ☐ negative.

Surgeries (Reason & Year)		Hospitalizations (Reason & Year)
1	5	1
2	6	2
3	7	3
4	8	4

Family History

Breast Cancer ☐ Yes ☐ No Who: Dx at Age: _____	Anesthesia Complications ☐ Yes ☐ No Who:
Ovarian Cancer ☐ Yes ☐ No Who: Dx at Age: _____	Birth Defects/Hereditary Disorders ☐ Yes ☐ No Who:
Uterine Cancer ☐ Yes ☐ No Who: Dx at Age: _____	High Blood Pressure ☐ Yes ☐ No Who:
Colon Cancer ☐ Yes ☐ No Who: Dx at Age: _____	Heart Disease ☐ Yes ☐ No Who:
Osteoporosis ☐ Yes ☐ No Who: Dx at Age: _____	Diabetes ☐ Yes ☐ No Who:
Gynecological Problems ☐ Yes ☐ No Who: Dx at Age: _____	Psychiatric Disorder ☐ Yes ☐ No Who:

Social History

Occupation	Marital Status ☐ Single ☐ Married ☐ Divorced	Social Drug Use ☐ Yes ☐ No Type: Amount: How often:
Cigarettes ☐ Yes ☐ No Pack/day: For how long: Quit date:		Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship
Alcohol ☐ Yes ☐ No Type: Amount: How often:		Do you have a medical power of attorney? ☐ Yes ☐ No If yes, please bring copy for your chart. ☐ Yes ☐ No

Review of Systems (Check all that apply and explain if necessary)

Constitutional ☐ Weight Loss ☐ Fever ☐ Fatigue ☐ Other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ Urinary frequency/urgency ☐ Caffeine/day ☐ Other
Neck ☐ Pain ☐ Difficulty swallowing ☐ Lumps ☐ Other	Skin/Breast ☐ Rash ☐ Lumps in breast ☐ Nipple discharge ☐ Pain in breast ☐ Other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ Other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ Other
Respiratory ☐ Cough ☐ Pain with breathing ☐ Shortness of breath ☐ Other	Lymphatic ☐ Lumps in groin, under arms, or in neck ☐ Other