Metro OBGYN Health History Form

Office Patient ID #_____

Please fill in all information on front and back of form

Today's Date_____

Name_____ Date of Birth _____/_____/_____

Referred by _____ Primary Care Doctor _____

Reason for today's visit _____

Menstrual History

First day of last period _____/_____/_____ Age at first period _____

Your periods occur every _____days and last for _____days

Any problems with your periods? □ No □ Yes
□ Heavy flow □ Clots □ Pain/Cramping □ Irregular periods □ Discharge
□ Bleeding between periods □ Other_____

If menopausal

Age/year began_____ Any Postmenopausal bleeding? □ No □ Yes

Gynecological History

Have you had any of the following? (Check all that apply)

□ Abnormal Pap Smear	□ Breast Pain	□ Chronic Pelvic Pain
□ DES Exposure	□ Endometriosis	□ Genital Warts
□ Infertility	□ Ovarian Cysts	□ Pain with Intercourse
□ PID	□ PMS	□ Recurrent Miscarriage
□ Recurrent Vaginitis	□ STD _____	
□ Urinary Incontinence	□ UTI (chronic)	□ Uterine Fibroids

□ **None of the above** *(additional medical history on the back of form)*

Contraceptive History

Are you currently sexually active? □ Yes □ No □ Never been

How many life time partners? _____ How many in the last year?_____

Current method of birth control (Include tubal or vasectomy) _____

Any problems with current method? □ No □ Yes _____

Previously used methods (Check all that apply)
□ Birth Control Pill □ Condoms □ Diaphragm □ Depo Provera □ IUD
□ NuvaRing □ Implanon □ Nexplanon □ Spermicide □ Sponge □ Other
□ No previous birth control

Preventive Care History

Last Pap Smear Date:_____ □ Normal □ Abnormal

Last Mammogram Date: _____ □ Normal □ Abnormal

Last Colonoscopy Date:_____ □ Normal □ Abnormal

Last DEXA (Bone Scan) Date: _____ □ Normal □ Abnormal

Last Cholesterol Test Date:_____ □ Normal □ Abnormal

Vaccinations (year) Gardasil _____ Flu _____
Herpes Zoster (Shingles) _____ TDAP (Tetanus) _____

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Surgical History (Please list all surgical procedures) □ None

Surgery_____ Date_____
Surgery_____ Date_____
Surgery_____ Date_____
Surgery_____ Date_____
Surgery_____ Date_____

Allergy History (List all medication allergies and reaction) □ None

Allergy_____ Reaction_____
Allergy_____ Reaction_____
Allergy_____ Reaction_____
Allergy_____ Reaction_____
Allergy_____ Reaction_____

Current Medication History

(Please include current prescriptions and medications ONLY) □ **None**

Drug name_____ Dose_____
Drug name_____ Dose_____
Drug name_____ Dose_____
Drug name_____ Dose_____
Drug name_____ Dose_____
Drug name_____ Dose_____

Social & Lifestyle History

Marital Status _____ Occupation_____

Tobacco Smoker □ Never □ Former □ Current - Amt/Day_____

Alcohol Use □ No □ Yes If yes, Amt/Wk_____

Caffeine Use □ No □ Yes Street Drugs/Marijuana use □ No □ Yes

Domestic Abuse □ No □ Yes If yes, □ Current or □ Past

Regular Exercise □ No □ Yes Type_____ Amt/Wk_____

Monthly Breast Exam□ No □ Yes Have you had Chicken Pox □ No □ Yes

Do you have a Health Care Directive (living will) □ No □ Yes

Past Medical History

	Indicate Relationship
Anemia	☐ Self ☐ Family ->
Anxiety	☐ Self ☐ Family ->
Asthma	☐ Self ☐ Family ->
Blood Clotting Disorder	☐ Self ☐ Family ->
Cancer; Breast	☐ Self ☐ Family ->
Cancer; Cervical	☐ Self ☐ Family ->
Cancer; Colon	☐ Self ☐ Family ->
Cancer; Ovarian	☐ Self ☐ Family ->
Cancer; Skin-type:_____	☐ Self ☐ Family ->
Cancer; Uterine	☐ Self ☐ Family ->
Cancer; Other ->	☐ Self ☐ Family ->
Cardiac Arrhythmia	☐ Self ☐ Family ->
Coronary Artery Disease	☐ Self ☐ Family ->
Crohn's Disease	☐ Self ☐ Family ->
Cystic Fibrosis	☐ Self ☐ Family ->
Deep Vein Thrombosis (DVT)	☐ Self ☐ Family ->
Depression	☐ Self ☐ Family ->
Diabetes-type:_____	☐ Self ☐ Family ->
Eating Disorder-type:_____	☐ Self ☐ Family ->
Gastric Ulcer	☐ Self ☐ Family ->
Gastroesophageal Reflux Disease	☐ Self ☐ Family ->
Gestational Diabetes	☐ Self ☐ Family ->
Hepatitis-type:_____	☐ Self ☐ Family ->
Hyperlipidemia (High Cholesterol)	☐ Self ☐ Family ->
Hypertension (High Blood Pressure)	☐ Self ☐ Family ->
Irritable Bowel Syndrome	☐ Self ☐ Family ->
Kidney Stones	☐ Self ☐ Family ->
Lupus	☐ Self ☐ Family ->
Migraines	☐ Self ☐ Family ->
Multiple Sclerosis	☐ Self ☐ Family ->
Osteoporosis	☐ Self ☐ Family ->
Parkinson's Disease	☐ Self ☐ Family ->
Pulmonary Embolism	☐ Self ☐ Family ->
Rheumatoid Arthritis	☐ Self ☐ Family ->
Scoliosis	☐ Self ☐ Family ->
Seizures	☐ Self ☐ Family ->
Sickle - Cell Disease	☐ Self ☐ Family ->
Sleep Apnea/Disorder	☐ Self ☐ Family ->
Stroke	☐ Self ☐ Family ->
Thyroid Disorder-type:_____	☐ Self ☐ Family ->
Tuberculosis	☐ Self ☐ Family ->
Ulcerative Colitis	☐ Self ☐ Family ->

Other Medical History we should know about ->

Are there any other problems that are important to you today?

☐ No ☐ Yes _____

_____

_____

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

Constitutional	Fever	☐ Yes	☐ No
	Chills	☐ Yes	☐ No
	Sweats	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Weight gain	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No
Eyes	Impaired Vision	☐ Yes	☐ No
Head, Ears, Nose, & Throat	Headaches	☐ Yes	☐ No
	Sinus Congestion	☐ Yes	☐ No
Breast	Lumps	☐ Yes	☐ No
	Tenderness	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Nipple Discharge	☐ Yes	☐ No
Cardiovascular	Chest pain	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No
Respiratory	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Cough	☐ Yes	☐ No
Gastrointestinal	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Blood in stools	☐ Yes	☐ No
Genitourinary	Urinary urgency	☐ Yes	☐ No
	Urinary frequency	☐ Yes	☐ No
	Urinary Incontinence	☐ Yes	☐ No
	Blood in urine	☐ Yes	☐ No
Integument (Skin)	Rash	☐ Yes	☐ No
	Change in moles, lesions	☐ Yes	☐ No
	Change in hair growth/loss	☐ Yes	☐ No
Neurologic	Muscular weakness	☐ Yes	☐ No
	Incoordination	☐ Yes	☐ No
	Tingling or numbness	☐ Yes	☐ No
Musculoskeletal	Joint pain	☐ Yes	☐ No
	Muscle pain	☐ Yes	☐ No
Endocrine	Excessive thirst	☐ Yes	☐ No
	Excessive urination	☐ Yes	☐ No
	Temperature intolerance	☐ Yes	☐ No
Psychiatric	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Feeling Confused	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No
	Excessive Anger	☐ Yes	☐ No
Heme-Lymph	Easy bleeding	☐ Yes	☐ No
	Easy bruising	☐ Yes	☐ No
	Swollen lymph glands	☐ Yes	☐ No
Allergic-Immunologic	Sinus allergy symptoms	☐ Yes	☐ No
	Frequent illnesses	☐ Yes	☐ No

Patient Signature:_____

Reviewed by:_____