

# HealthONE OB/GYN Patient History

Date: \_\_\_\_\_

Name: \_\_\_\_\_ If different, preferred name: \_\_\_\_\_ Age \_\_\_\_\_

Preferred gender identity: Female Male Transgender Male/FTM Transgender Female/MTF Gender Queer Other

Sex assigned at birth: Female Male Other Decline to answer

Would you like a chaperone in the room for your exams? Yes No

## MEDICATIONS:

Name	Strength/Dose	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies and reaction: \_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_ Address or cross streets: \_\_\_\_\_

## MEDICAL HISTORY: No Medical Problems

- |  |   |  |  |
|--|---|--|--|
| <input type="radio"/> Allergies                | <input type="radio"/> Blood clots (legs, lungs) | <input type="radio"/> Eating Disorder      | <input type="radio"/> Hypertension         |
| <input type="radio"/> Anemia                   | <input type="radio"/> Bowel Disease             | <input type="radio"/> GERD/Acid Reflux     | <input type="radio"/> Kidney Disease       |
| <input type="radio"/> Anxiety                  | <input type="radio"/> Cancer                    | <input type="radio"/> Headaches/Migraines  | <input type="radio"/> Osteoporosis         |
| <input type="radio"/> Arthritis                | <input type="radio"/> COPD                      | <input type="radio"/> Heart Disease/Murmur | <input type="radio"/> Stroke               |
| <input type="radio"/> Asthma                   | <input type="radio"/> Depression                | <input type="radio"/> Hepatitis            | <input type="radio"/> Substance dependence |
| <input type="radio"/> Blood transfusion (past) | <input type="radio"/> Diabetes                  | <input type="radio"/> High Cholesterol     | <input type="radio"/> Thyroid disease      |
| <input type="radio"/> Other _____              |   |  |  |

## GYNECOLOGICAL HISTORY:

First day of your last menstrual period (LMP): \_\_\_\_\_ How old were you when your period started? \_\_\_\_\_  
Are your periods: Light Moderate Heavy Are periods regular in their timing? Yes No  
How many days between your periods? \_\_\_\_\_ How many days of menstrual flow? \_\_\_\_\_  
Do you have remarkable pain with your periods? Yes No Do you have bleeding in-between periods? Yes No  
If applicable, age of menopause/year of last period? \_\_\_\_\_ Taken hormone meds taken since menopause? Yes No  
Do you have any urinary or fecal incontinence? Yes No  
Do you have any concerns or questions about your sexual health? Yes No  
Are you sexually active now? Yes No  
Sexual orientation: Straight Gay Lesbian Bisexual  
Current relationship status, circle all that apply: Single Married In a civil union Domestic partnership Multiple partners  
Partnered, not cohabitating Divorced Widowed In a committed relationship Other: \_\_\_\_\_

Name of partner(s): \_\_\_\_\_

Current form of birth control: \_\_\_\_\_ Are you happy with it? Yes No

Past methods of birth control (select all that apply): Rhythm/Natural Family Planning Condoms Withdrawal Pill Patch  
Nuvaring Depo-Provera Injections Arm Implant Hormone IUD Copper IUD Essure Sterilization Tubal Ligation  
Vasectomy Hysterectomy

Date of last Pap test: \_\_\_\_\_ Was it normal? Yes No Ever had an abnormal Pap or Colposcopy? Yes No

Have you had any treatments to your cervix? No Cryosurgery Laser Surgery LEEP Conization Other \_\_\_\_\_

Have you ever had a sexually transmitted disease? No Chlamydia Gonorrhea Herpes Other \_\_\_\_\_

Have you had the HPV vaccine (Gardasil) series? Yes No

**FAMILY HISTORY:** Check middle column if there is a family history of:

Illness	X	Family Member (example: Sister or Maternal Grandfather)
Diabetes		
High Blood Pressure		
Coronary Artery Disease/Heart attack		
High Cholesterol		
Breast Cancer		
Ovarian Cancer		
Lung Cancer		
Colon Cancer		
Pancreatic cancer		
Melanoma		
Substance dependence		
Depression/Anxiety		
Asthma		
Other		

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Who do you live with at home? \_\_\_\_\_

Do you have history of substance dependence? Yes No

How many alcoholic drinks do you have per week: \_\_\_\_\_

In the last year, have you felt guilty about your drinking, had more than 4 drinks in a day, or lost memory due to drinking? Yes No

Do you use recreational drugs (Marijuana, IV drugs, prescription drugs not prescribed to you)? Yes No

If yes to the above, what do you use and how often? \_\_\_\_\_

Do you currently smoke? Yes No

Are you ready to discuss quitting today? Yes No

Have you EVER been a smoker? Yes No

If yes: What age did you start smoking?: \_\_\_\_\_ #/day: \_\_\_\_\_ When did you quit? \_\_\_\_\_

**PAST OPERATIONS/HOSPITALIZATIONS:**  No Surgical History

Appendectomy  Heart Surgery  Colon Surgery  Fracture/Trauma  Plastic Surgery  Brain/Spine

Breast Surgery  Hysterectomy  Hernia Repair  Tubal ligation  Joint Replacement  C-section

Cholecystectomy (gallbladder)  Other GYN surgery: \_\_\_\_\_

Other surgery: \_\_\_\_\_

**HEALTH CARE SCREENING QUESTIONS**

Have you had a mammogram? Yes No Date of last mammo: \_\_\_\_\_

Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? Yes No

Have you had a colonoscopy? Yes No Date of last colonoscopy: \_\_\_\_\_

Have you had a bone density test, for example DEXA scan? Yes No

Do you adhere to any particular diet? Yes No If so, what diet? \_\_\_\_\_

Do you exercise regularly? Yes No

If you exercise regularly, what type and how often do you exercise? \_\_\_\_\_

Has anyone close to you ever threatened to hurt you? Yes No

Has anyone ever hit, kicked, choked or hurt you physically? Yes No

Has anyone ever forced you into a sexual experience? Yes No

Have you ever traded sexual acts for money, rent, food, services? Yes No

Are you or have ever been afraid of your current partner? Yes No

Do you wear a seatbelt? Yes No

Do you wear sunscreen? Yes No

Do you have any guns in your home? Yes No

Are you planning a trip or have you been to a Zika endemic area in the last year? Yes No

Country you traveled to: \_\_\_\_\_ Travel Date: \_\_\_\_\_

Are you currently involved in any legal proceedings that may impact our care for you? Yes No

**PREGNANCY HISTORY:** Please list all pregnancies in the table below, for pregnancies that you carried past 20 weeks please list any complications during the pregnancy, labor, delivery or post-partum period including preterm hospitalizations, depression/anxiety, gestational diabetes, high blood pressure/pre-eclampsia, weight gain greater than 35 pounds, stillbirth, 3<sup>rd</sup> or 4<sup>th</sup> degree delivery laceration, episiotomy, breech delivery, post-partum bleeding, uterine infection/chorioamnionitis, lactation concerns.

Date	Result of pregnancy	Weeks at end of pregnancy	Mode of Delivery	If delivered, sex of baby and name	Infant weight	Name of partner in pregnancy	Complications
	<input type="checkbox"/> Delivery <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum				

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 2 WEEKS?**

- |     |    |                                    |     |    |                                |
|-----|----|------------------------------------|-----|----|--------------------------------|
| Yes | No | Unexplainable weight change        | Yes | No | Blood in stools                |
| Yes | No | Fever/Chills                       | Yes | No | Nausea/vomiting                |
| Yes | No | Vision Changes                     | Yes | No | Abdominal pain                 |
| Yes | No | Headaches                          | Yes | No | Frequent urination             |
| Yes | No | Chest pain                         | Yes | No | Painful urination              |
| Yes | No | Shortness of breath at rest        | Yes | No | Loss of urine                  |
| Yes | No | Skipped beat or heart palpitations | Yes | No | Blood in the urine             |
| Yes | No | Blood Clots                        | Yes | No | New skin rashes                |
| Yes | No | Breast lump or mass                | Yes | No | Mole changes                   |
| Yes | No | Cough                              | Yes | No | Anxiety                        |
| Yes | No | Wheezing                           | Yes | No | Depression                     |
| Yes | No | Nipple discharge                   | Yes | No | Suicidal or homicidal thoughts |
| Yes | No | Constipation                       | Yes | No | Heat/cold intolerance          |
| Yes | No | Diarrhea                           | Yes | No | Numbness/Tingling              |
| Yes | No | Extremity swelling                 | Yes | No | Weakness                       |
| Yes | No | Joint Pain                         |     |    |                                |

Physician Signature \_\_\_\_\_ Date reviewed: \_\_\_\_\_