PLYMOUTH OB/GYN MEDICAL HISTORY Date _____

Name _____ Date of Birth _____ Age _____

Referred By _____ Primary Care Provider _____

Have you been seen here before?_____ When?_____ Your occupation:_____

Single Married Divorced Widowed Separated Spouse or partner's name _____

Allergies to medication, x-ray dyes, latex, anesthesia or other substances?

No **Yes** (please list name of medication and type of reaction)

GYNECOLOGIC AND OBSTETRICAL HISTORY

Number of pregnancies _____
Number of living children _____
Miscarriages _____
Abortions _____

Age at onset of periods _____
Number of days apart _____
Duration of bleeding _____
First Day of Last Period _____

Please List month, year for each pregnancy (include type of delivery, and sex of baby if applicable)

_____

_____

Prolonged or abnormal bleeding…… no yes

Leakage of urine……no yes

History of abnormal Pap smear……...no yes

Complications of childbirth……...no yes

Hormone Replacement Therapy…….no yes Method _____

sexually Transmitted Diseases……..no yes

Pelvic pain……..no yes

Abnormal vaginal discharge……no yes

Current Birth Control:_____

Most recent colonoscopy: Where:_____ When:_____

PAST MEDICAL HISTORY

Please circle if you have had a history of or are having problems with any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Abdominal pain
6. Change in bowel habits
7. Unexplained weight loss/gain
8. Thyroid disease
9. Headache
10. Infertility
11. Frequent urination
12. Difficulty urinating
13. Anxiety
14. Depression
15. Arthritis
16. High Cholesterol
17. Alcohol/drug problems
18. Reaction to anesthesia
19. Osteoporosis
20. Seizures
21. Anemia

Other _____

OVER!

PLYMOUTH OB/GYN MEDICAL HISTORY PAGE 2

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHARMACY: _____

MEDICATIONS and Dosages (Prescription, or Over the Counter, Vitamins or Herbs)

_____
_____
_____

SOCIAL HISTORY and HEALTH RISKS

Habit	Former	Current	Never	
Tobacco use	□	□	□	How much? _____ How Long? _____Year Quit_____
Drug Use	□	□	□	What type?_____
Alcohol Use	□	□	□	How many drinks per day?_____
Caffeine Use	□	□	□	How much? _____
Regular Exercise	□	□	□	What type? _____ How Often? _____

Have you ever engaged in any activity which has put you at risk for HIV/AIDS?	□	□
Have you been in a relationship in which you've been physically hurt by someone?	□	□
Do you ever feel afraid of your partner?	□	□

FAMILY HISTORY

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Yes	Which family members?
Diabetes		
High Blood Pressure		
Heart Disease		
Thyroid Problems		
Anxiety/Depression		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Alcoholism		
Other		