Plymouth OB/GYN Medical History Date:_____

Name_____DOB:_____ Pharmacy_____

Have you been here before? When_____ PCP/Referred By_____

Spouse/Partners Name_____ Single Married Divorced Occupation_____

Allergies to Medication? NO YES What kind and what is your reaction?

_____

MEDICAITONS (prescription, over the counter and DOSAGES)

_____

_____

GYN/OB HISTORY

Age at onset of periods:	Duration of bleeding:	First day of last period:

Number of pregnancies	Please list month/year for each pregnancy and type of delivery:
Number of living children	
Miscarriages	
Abortions	

	YES	NO	
Prolonged or abnormal bleeding			Complications of childbirth?
Leakage of urine			
History of abnormal pap smear			Current Hormone replacement?
Sexually transmitted disease			
Pelvic pain			Current birth control? Type
Abnormal vaginal discharge			

Have you ever engaged in activity which put you at risk for HIV/AIDS?	Yes	No
Have you ever been in a relationship where you've been physically hurt?	Yes	No
Do you ever feel afraid of your partner?	Yes	No

In the past 2 weeks, have you experienced? Please circle

Little Interest or Pleasure in Doing Things? Not at all Several days More than ½ the days Nearly all

Feeling Down, Depressed or Hopeless? Not at all Several days More than ½ the days Nearly all

SOCIAL HISTORY/HEALTH RISKS

Habit	Former	Current	Never			
Tobacco				How Much?	How Long?	Year Quit:
Drug Use				What type?		
Alcohol Use				How Many Per Day?		
Caffeine Use				How Much Per Day		
Exercise	What Type?			How often?		

Past/Current Medial Information: please circle if you have had or do have any of the following.

High blood pressure	Thyroid disease	Arthritis
Diabetes	Headache/migraines	High cholesterol
Cancer	Infertility	Alcohol/drug problems
Heart disease	Frequent urination	Reaction to anesthesia
Abdominal pain	Difficulty urination	Osteoporosis
Change in bowel habits	Anxiety	Seizures
Unexplained weight loss/gain	Depression	anemia

SURGERIES/ HOSPITALIZATIONS

Reason and Date Reason and Date

_____

_____

_____

FAMILY HISTORY--Has any member of your family ever had or currently have the following?

	Mother	Father	MGM	MGF	PGM	PGF	Sibling	Other
Alcoholism								
Anxiety								
Asthma								
Breast Cancer								
Ovarian Cancer								
Uterine Cancer								
Colon Cancer								
Depression								
Diabetes								
Heart Attack								
Heart Disease								
Hyperlipidemia								
Hypertension								
Stroke								
Thyroid Disease								
Other								