GROS VENTRE OB/GYN PATIENT HISTORY FORM

DATE_____

Name _____

Address _____ Age_____

Marital Status (circle one): Single Married Divorced Separated Widowed Referred By_____

Reason for today's visit: _____

_____

First day of last menstrual period _____ When was your last pap smear? _____

Periods come every _____ days. They last ____ days. Have you ever had an abnormal pap? Yes No

Periods are (circle one) light moderate heavy If yes, please explain _____

Do you ever bleed between periods? Yes No

If yes, please explain _____

Date of last mammogram _____ Was it normal? _____

Do you practice monthly self breast exams? Yes No

Date of last Bone Density testing _____ Date of last Colonoscopy _____

Please list all medications _____

_____

Are you allergic to any medication(s)? _____

What is your method of birth control? _____ Do you have any problems with this method? _____

Have your ever been sexually assaulted or abused? _____

Do you currently suffer from physical abuse from your partner? _____

Are you sexually active? _____ What is your sexual preference? _____

Do you have any problem with sexual relations? _____

Have you ever been pregnant? Yes No How many times? _____ How many children do you have? _____

Do you smoke cigarettes or chew tobacco? _____ How many per day? _____

Do you drink alcohol? _____ How many per day? _____

Do you use non-prescription drugs? _____ Do you exercise regularly? _____

Have you ever had a high triglyceride or cholesterol level? _____ If so, when? _____

Are you comfortable with your current body weight? _____ Have you ever been diagnosed with a mental illness? _____

Have you ever had any of the following STD's? (circle all that apply) **Genital Herpes** **Chlamydia** **Gonorrhea** **HIV** **HPV/Genital Warts** **Syphilis**

Do you have any long term medical problems? Yes No If yes, please explain _____

_____

Have you every had a surgery of any type? Yes No If yes, please list YEAR and PROCEDURE _____

_____

_____

Family History	Family Member	Age Diagnosed
Diabetes		
High Blood Pressure		
Heart Attack		
Stroke		
Thyroid Disease		
Osteoporosis		
Breast Cancer		
Cancer of Uterus and/or Ovaries		
Blood Clot / Blood Disorders		
Seizures		
Colon Cancer		

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Do you have any other questions or concerns? _____

Are you under anyone else's care? _____