CONCORD OB/GYN Medical History

Date: _____

Legal Name: _____ Chosen Name: _____ Date of Birth: _____

Preferred Pronouns (circle): she/her he/him they/them other: _____

Gender Identity: female ☐ non-binary ☐ transgender male ☐ other: _____

Primary Care Provider: _____ Pharmacy: _____

What is the reason for your visit today? _____

Gynecological History

Have you ever been vaccinated for HPV- Gardasil_____ Yes ☐ No ☐
Last PAP Smear_____
Last Mammogram_____
Last Bone Density (DEXA) _____
Last Colonoscopy_____
Have you ever been on hormone replacement therapy (HRT)? _____ Yes ☐ No ☐
Any personal history of:
Abnormal Pap Smear_____ Yes ☐ No ☐
Have you ever had a sexually transmitted disease? _____ Yes ☐ No ☐
If yes, which one(s)? HPV ☐ Chlamydia ☐ Gonorrhea ☐ HSV ☐ HIV ☐
Syphilis ☐ Trichomoniasis ☐ Hepatitis ☐
Fibroids_____ Yes ☐ No ☐
Endometriosis_____ Yes ☐ No ☐
Infertility_____ Yes ☐ No ☐
Urinary Incontinence_____ Yes ☐ No ☐

Menstrual History

First day of last menstrual period _____
Age at first menstrual period _____
Number of days between periods _____
Number of days that you bleed _____
Describe the menstrual flow _____ light/moderate/heavy/clots
Describe the amount of menstrual discomfort _____ none/mild/moderate/severe
Do you bleed in between your periods? _____ Yes ☐ No ☐
Do you bleed after intercourse? _____ Yes ☐ No ☐
If you stopped menstruating, at which age did you stop? _____
Have you had bleeding or spotting since your period stopped? _____ Yes ☐ No ☐

Contraceptive and Sexual History

Present contraception method _____
Contraception methods used in the past (list): _____
Have you ever been sexually active? _____ Yes ☐ No ☐
What is your sexual orientation? heterosexual/straight ☐ homosexual ☐ bisexual ☐ asexual ☐ other: _____
What is/are the gender(s) of your current sexual partner(s)? _____
Do you experience pain or discomfort with sexual intercourse? _____ Yes ☐ No ☐
Would you like to discuss sexual activity or birth control today? _____ Yes ☐ No ☐

Obstetrical History

Pregnancies _____ Living Children _____ Vaginal Births _____ C-Sections _____
Miscarriages _____ Abortions _____ Ectopic Pregnancies _____
List any complications of pregnancy or delivery _____

Medical History

Have you or a family member had the following? Please describe.

	YOU	Family Member
Genetic Disease/Blood Clotting Disorders	_____	_____
Heart Disease	_____	_____
Hypertension	_____	_____
Thyroid Condition	_____	_____
Kidney Disease	_____	_____
Diabetes	_____	_____
Hepatitis/Liver Disease	_____	_____
Respiratory Disease	_____	_____
Psychiatric Disease	_____	_____
Breast Cancer	_____	_____
Uterine Cancer	_____	_____
Ovarian Cancer	_____	_____
Colon Cancer	_____	_____
Stroke/Migraines	_____	_____
Other major illness/ medical problems	_____	_____

Surgical History

Have you ever had surgery? Yes ☐ No ☐ If so, what kind? _____
Have you or family members had difficulty with anesthesia? _____

Personal/Social History

Occupation: _____
Do you exercise? Yes ☐ No ☐ How often? _____
Do/Did you use tobacco or marijuana products? Yes ☐ No ☐ How much? _____
Do/Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? _____
Do/Did you use illicit drugs? Yes ☐ No ☐ which drugs did you use? _____
Have you ever been a victim of physical, verbal, emotional or sexual abuse? _____

Current Medications

Medicine	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (Medication, Food, Environmental)

❑ NO KNOWN ALLERGIES

Allergen	Type of Reaction
_____	_____
_____	_____
_____	_____

CONCORD OB/GYN

Today's Date: _____

Legal Name: _____ Date of Birth: _____

Review of Systems

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed.

Constitutional (Health in General) ❑ No Problems
Unexplained weight loss, unexplained weight gain, fever, fatigue, hot flashes, or night sweats.
Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems
Ulcers, sinus problems, headache, or hearing loss. Other: _____

Cardiovascular (Heart & Blood Vessels) ❑ No Problems
Difficulty with breathing while lying down, chest pain, difficulty breathing with activity, swelling of feet or legs, or racing heart. Other: _____

Respiratory (Lungs & Breathing) ❑ No Problems
Wheezing, coughing up blood, shortness of breath, or cough. Other:_____

GI (Stomach & Intestines) ❑ No Problems
Diarrhea, blood in stool, nausea, vomiting, indigestion, constipation, gas, abdominal pain, or fecal incontinence. Other:_____

Genital ❑ No Problems
Pain with intercourse, abnormal or painful periods, PMS, abnormal vaginal bleeding, irregular vaginal discharge, pelvic pain, bloating, early satiety, postmenopausal bleeding, bleeding between periods, or bleeding after sex. Other: _____

GU (Kidney & Bladder) ❑ No Problems
Blood in urine, pain with urination, urgency, frequency, incomplete emptying, urgency incontinence, stress incontinence, frequent nighttime urination. Other:_____

MS (Muscles, Bones, Joints) ❑ No Problems
Muscle weakness, muscle pain, joint pain, or back pain. Other: _____

Integument (Skin, Hair & Breast) ❑ No Problems
Persistent rash, ulcers, dry skin, or areas of color change. Other: _____

Breast ❑ No Problems
Breast pain, nipple discharge, masses, or an abnormal mammogram. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems
Fainting, seizures, numbness, trouble walking, or severe memory problems. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems
Insomnia, irritability, depression, crying, or severe anxiety. Other: _____

Endocrine (Glands) ❑ No Problems
Diabetes, hypothyroidism or hyperthyroidism, hot flashes, hair loss, intolerance to heat or cold, or night sweats. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems
Easy bruising, easy bleeding, anemia, or unexplained swollen areas. Other:_____