CONCORD OB/GYN Medical History

Date: ____________

Name: ____ Preferred Name: _______________

Date of Birth: __________________________ PCP: _________________________________

Pharmacy: ____

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 therapy_________________________________ Yes [ ] No [ ]
Any personal history of:
Abnormal Pap Smear____ Yes [ ] No [ ]
Sexually transmitted disease____ Yes [ ] No [ ]
List: ____
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 birth control method ____
Birth control methods used in the past:
1.___________________________________2.______________________________
3.___________________________________4.______________________________
Have you ever been sexually active (had intercourse)? _____________________ Yes [ ] No [ ]
How many sexual partners have you had in the past 3 months? ________________
Is/Are your partner(s) male, female, both? _____________________________
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 ________________________________ **(SEE REVERSE)**

Medical History

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

	YOU	Family Member
Genetic Disease	______________________________	______________________
Heart Disease	______________________________	______________________
Hypertension	______________________________	______________________
Thyroid Condition	______________________________	______________________
Kidney Disease	______________________________	______________________
Diabetes	______________________________	______________________
Hepatitis or Liver Disease	______________________________	______________________
Respiratory Disease	______________________________	______________________
Psychiatric Disease	______________________________	______________________
Breast Cancer	______________________________	______________________
Uterine Cancer	______________________________	______________________
Ovarian Cancer	______________________________	______________________
Colon Cancer	______________________________	______________________
Stroke	______________________________	______________________
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
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

What is the reason for your visit today?

____

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CONCORD OB/GYN

Today's Date: ____________

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
Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, prior diagnosis of cancer. Other: ___________________________________

Ears, Nose, Mouth & Throat ❑ No Problems
Sinus problems, ringing in ears, nosebleeds, sore throat, facial pain or numbness. Other: _____________

Cardiovascular (Heart & Blood Vessels) ❑ No Problems
Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: ____

Respiratory (Lungs & Breathing) ❑ No Problems
Shortness of breath, night sweats, prolonged cough, wheezing. Other:____________________________

GI (Stomach & Intestines) ❑ No Problems
Heartburn, constipation, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:_______________________________________

GU (Kidney & Bladder) ❑ No Problems
Painful urination, frequent urination, urgency, incontinence. Other:_________________________________

MS (Muscles, Bones, Joints) ❑ No Problems
Joint pain, aching muscles, swelling of joints, back pain. Other: ____________________________________

Integument (Skin, Hair & Breast) ❑ No Problems
Persistent rash, itching, new skin lesion, hair loss or increase, breast changes. Other: __________________

Neurologic (Brain & Nerves) ❑ No Problems
Frequent headaches, double vision, weakness. Other: ____

Psychiatric (Mood & Thinking) ❑ No Problems
Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ____

Endocrine (Glands) ❑ No Problems
Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: ____

Hematologic (Blood/Lymph) ❑ No Problems
Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other:____