Seasons of Life
Obstetrics & Gynecology, PC

PATIENT HEALTH HISTORY

Gynecologic and Genitourinary Problems *(Please check all that apply.)*

□ Heavy periods □ Frequent periods □ Absent or infrequent periods □ Cramps
□ Abnormal Pap □ Vaginal discharge □ Vaginal itching □ Vaginal dryness
□ Pelvic Pain □ Endometriosis □ Ovarian cysts □ Fibroids □ Uterine polyps
□ Premenstrual symptoms □ Bleeding with intercourse □ Pain with intercourse
□ Sexual problems □ Infertility □ Pelvic organ prolapse □ Frequent bladder infections
□ Urine leakage □ Urinary frequency □ Urinary urgency □ Osteoporosis
□ Abnormal Mammogram □Breast lump □ Breast pain □ Nipple discharge
□ Hot flashes □ Mood changes □ Postmenopausal bleeding
□ Other: _____

_____

Sexually Transmitted Infection History *(Please check all that apply)*

□ Gonorrhea □ Chlamydia □ Pelvic Inflammatory Disease (PID) □ HIV □ Herpes
□ Trichomonas □ Syphilis □ Genital warts □ HPV □ Hepatitis B □ Hepatitis C

PAST SURGERIES and HOSPITALIZATIONS:

_____

_____

_____

MEDICATIONS: *(Please list current medication, dose, and frequency.)*

_____

_____

_____

VACCINES:

_____

_____

_____

ALLERGIES: *(Please list any medications, latex, or other allergies followed by reaction.)*

_____

_____

_____

PAST MEDICAL HISTORY : (Please check all that apply.)

□ Diabetes □ High Blood Pressure □ Heart Disease □ Stroke □ Cancer
□ Seizures □ Thyroid Disease □ High Cholesterol □ Asthma □ Anemia
□ Blood Clots □ Kidney Disease □ Liver Disease □ Gastrointestinal Disorders
□ Eating Disorder □ Depression □ Anxiety □ Psychiatric Disorder □ Headaches
□ Other: _____

_____

_____

SOCIAL HISTORY:

Occupation: _____

Employer: _____

Highest education level: _____

Are you a student? □ Yes □ No If Yes, what grade level? _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

What is your stress level? □ Low □ Medium □ High
Do you exercise regularly? □ Yes □ No
If Yes, what type of exercise? _____ How often? _____

What type of diet do you follow?
□ Regular □ Vegetarian □ Vegan □ Gluten-free □ Other: _____

Tobacco use? □ Yes □ No
If Yes, how many cigarettes per day? _____ How long? _____
Alcohol use? □ Yes □ No If Yes, how many drinks per week? _____
Drug use? □ Yes □ No If Yes, what type? _____ How often? _____
Caffeine? □ None □ Occasional □ Moderate □ Heavy

Are you sexually active? □ Yes □ No If yes, how many partners? _____
Do you have unprotected sex? □ Never □ Sometimes □ Always

Have you ever been physically or sexually abused? □ Yes □ No
Are you being abused now? □ Yes □ No

FAMILY HISTORY:

□ Check here if adopted or unknown family history.

Disease	Family Member(s)	Age at Diagnosis
**Please specify maternal (mother's side) or paternal (father's side)*		
□ Breast Cancer	_____	_____
□ Gynecologic Cancer (Uterine, Ovarian, Cervical, etc.)	_____	_____
□ Other Cancers (list type) (Colon, Melanoma, Lung, etc.)	_____	_____
□ Heart Disease	_____	_____
□ Hypertension	_____	_____
□ High Cholesterol or Triglycerides	_____	_____
□ Diabetes	_____	_____
□ Osteoporosis, Bone Fractures	_____	_____
□ Blood Clots	_____	_____
□ Alzheimer's Disease	_____	_____

GYNECOLOGIC HISTORY :

Age of first period _____ years
Interval between periods _____ days
Amount of pads/ tampons used per day _____

First day of last period _____
Length of each period _____ days

Age of first intercourse _____ Sex with □ Men □ Women □ Both
Current method of birth control: _____
Desired method of birth control: _____

Date of last Pap smear: _____ □ Normal □ Abnormal
Date of last mammogram: _____ □ Normal □ Abnormal
Date of last colonoscopy: _____
Date of last bone density scan: _____

Gynecologic Surgical History *(Please list year and procedure)*

_____
_____
_____
_____

FAMILY PHYSICIAN/ PCP INFORMATION

Practice Name: _____
Physician Name: _____
Office Address: _____
Office Phone: _____

PHARMACY INFORMATION

Primary Pharmacy: _____
Address: _____
_____
Phone: _____

Secondary Pharmacy: _____
Address: _____
_____
Phone: _____

OBSTETRIC HISTORY :

Have you ever been pregnant? □ Yes □ No *(If No, please skip to next section.)*
How many times have you been pregnant? ____
How many living children do you have? ____

Vaginal Deliveries (Dates): _____
Cesarean Deliveries (Dates): _____
Preterm Deliveries (Dates): _____
Miscarriages (Dates): _____
Abortions (Dates): _____
Ectopic Pregnancies (Dates): _____

Obstetrical Complications *(Please check all that apply.)*

□ Diabetes in pregnancy □ Pre-eclampsia □ Eclampsia □ Stillbirth □ Fetal anomaly
□ Poor fetal growth (IUGR) □ Excessive fetal growth (Macrosomia)
□ Placental abruption □ Placenta previa (placenta covers the cervical os)
□ Postpartum hemorrhage □ Preterm labor □ Premature delivery
□ Twin pregnancy □ Triplet or higher pregnancy
□ Low amniotic fluid (Oligohydramnios) □ High amniotic fluid (Polyhydramnios)
□ Cervical insufficiency or Loss of second-trimester pregnancy □ Recurrent miscarriage
□ Other: _____
_____
_____

QUESTIONS: Do you have any particular concerns, needs, questions or comments?

_____
_____
_____
_____
_____
_____
_____