HEALTH HISTORY FORM

REASON FOR VISIT: ROUTINE OB CARE WELL WOMAN VISIT PROBLEM (PLEASE LIST):_____

PREFERRED PHARMACY: _____ **PHARMACY LOCATION:** _____

PRIMARY CARE PHYSICIAN: _____

ALLERGIES: _____

LIST ANY CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL): _____

_____

HAVE YOU HAD THE INFULENZA VACCINE? YES NO PNUEMONIA VACCINE IN THE LAST 5 YEARS? (>65 YEARS OLD) YES NO

HAVE YOU RECEIVED THE COVID-19 VACCINE? YES NO

GYN HISTORY:

LAST MENSTRUAL PERIOD_____ LENGTH OF CYCLE FLOW_____ HOW MANY DAYS BETWEEN YOUR PERIODS _____

DO YOU HAVE A PERIOD EVERY MONTH: YES NO IS YOUR FLOW: LIGHT MEDIUM HEAVY

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD: _____

CURRENT BIRTH CONTROL: (INCLUDES VASECTOMY, TUBAL, CONDOMS, IUD, SHOTS, PILLS, PATCHES, RINGS) OR NONE: _____

IF POST-MENOPAUSAL, AGE AT MENOPAUSE: _____

WHEN WAS YOUR LAST COLONOSCOPY? (IF OVER 50YRS OLD)_____

WHEN WAS YOUR LAST BONE DENSITY TEST (IF OVER 50YRS OLD) _____

WHEN WAS YOUR LAST MAMMOGRAM (IF OVER 40 YRS OLD) _____

HAVE YOU EVER HAD THESE SEXUALLY TRANSMITTED DISEASES?

HERPES: YES NO HIV: YES NO GONORRHEA: YES NO SYPHILLIS: YES NO

CHLAMYDIA: YES NO TRICHOMONAS: YES NO HPV: YES NO

OBSTETRIC HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ HOW MANY LIVING CHILDREN DO YOU HAVE? _____

RECORD OF PAST PREGNANCIES:

DATE OF DELIVERY or MISCARRIAGE	TERM DELIVERY OR PRETERM DELIVERY? (Weeks)	BABY'S BIRTH WEIGHT	SEX OF BABY	ANESTHESIA	COMPLICATIONS

HAS ANY OF YOUR FAMILY HAD THE FOLLOWING CONDITIONS?

PLEASE SPECIFY MATERNAL OR PATERNAL SIDE OF FAMILY AND RELATION TO YOU

Example: Paternal side, aunt; Maternal side grandmother; brother/sister

	Yes	Mother (M) Father (P) Relation to you		Yes	Mother (M) Father (P) Relation to you
Anesthesia complications			Heart Problems		
Anxiety Disorder			Hepatitis		
Asthma			High Blood Pressure		
Bipolar Disorder			High Cholesterol		
Birth Defect or Inherited Disease			Kidney Disease		
Breast Cancer			Mental Retardation (Chromosome Disorders)		
Breast problems			Osteoporosis		
Cancer			Ovarian Cancer		
Cervical Cancer			Pulmonary Embolism		
Cystic Fibrosis			Seizures/Epilepsy		
Depression			Sickle Cell Disease/Trait		
Diabetes			Stroke		
Diverticulitis			Tay Sachs		
Endometriosis			Thalassemia		
Fibroids			Thyroid Problems		
Fragile X			Uterine Cancer		
Heart Disease			Varicose Veins		

SOCIAL HISTORY:

(CIRCLE ONE) MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPERATED SINGLE WIDOWED

WHAT KIND OF WORK DOES YOUR PARTNER DO? _____ NAME OF BABY'S FATHER: _____

WHAT KIND OF WORK DO YOU DO: _____ HIGHEST GRADE YOU COMPLETED: _____

EXERCISE LEVEL: NONE OCCASIONAL, MODERATE, HEAVY DIET: _____

ALCOHOL INTAKE: NEVER OCCASIONAL DAILY CAFFIENE INTAKE: NONE OCCASIONAL, MODERATE, HEAVY

SMOKING HISTORY: NEVER FORMER DAILY OCCASIONALLY AMOUNT: _____ HOW MANY YEARS: _____

HISTORY OF OR CURRENT DRUG USE: YES NO LIST ANY STREET DRUGS USED IN THE LAST YEAR: _____

DO YOU USE A SEATBELT ROUTINELY? YES NO DO YOU USE SUNSCREEN ROUTINELY? YES NO

WHO LIVES WITH YOU? _____ NUMBER OF CHILDREN IN THE HOUSE: _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL SEXUALLY ACTIVE: YES NO

SURGERIES (LIST TYPE OF SURGERY AND APPROXIMATE YEAR INCLUDING C-SECTION, TUBAL, D&C, BLADDER SUSPENSION):

Surgery Type and Year	Surgery Type and Year

List any hospitalizations not related to childbirth:

_____ _____

HAVE **YOU** HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes		**Yes**
Abnormal pap		Heart Disease	
Anemia		Heart Problems	
Anesthesia complications		Hepatitis	
Anxiety Disorder		High Blood Pressure	
Asthma		High Cholesterol	
Bipolar Disorder		Hyperthyroidism	
Birth Defect or Inherited Disease		Hypothyroidism	
Bladder or Kidney Problems		Infertility	
Blood Diseases		Kidney Disease	
Breast Cancer		Liver Disease	
Breast problems		Lung Disease	
Cancer		Muscle, Joint or Bone	
Cervical Cancer		Osteoporosis	
COPD		Ovarian Cancer	
Cystic Fibrosis		Pulmonary Embolism	
Depression		Seizures/Epilepsy	
Diabetes		Sickle Cell Disease	
Diverticulitis		Sickle Trait	
Endometriosis		Stroke	
Fibroids		Tay Sachs	
Fibromyalgia		Thalassemia	
GERD/Reflux		Thyroid Problems	
GI problems		Uterine Cancer	
Hearing problems		Varicose Veins	
Headaches		Vision or Eye Problems	
Migraines			

Any other conditions not listed above: _____