OB-GYN Patient History Form

Name:		Date:
Age:	Height:	Weight:
Occupation:		Marital status:
Partner's name:		
Partner's age:	Partner's occupation:	
Why has your care provider referred you?		

Menstrual History	
Age at first period:	Age at menopause:
Period occurs every _________ days	
Duration of bleeding: ___________ days	
Date of last menstrual period:	
Do you have bleeding or spotting between periods?	Yes ☐ No ☐
Does bleeding occur after intercourse?	Yes ☐ No ☐
Does pain occur with periods?	Yes ☐ No ☐
Do you currently have abnormal vaginal discharge?	Yes ☐ No ☐

Pregnancy History

Date	Place of delivery or abortion	Duration of pregnancy	Hours of labour	Type of delivery	Complications	Sex	Birth weight	Present health

Contraception History	
What method of contraception do you currently use?	
What methods have you used in the past?	

Sexual History	
Have you ever had sexual intercourse?	Yes ☐ No ☐
Do you currently have a sexual partner?	Yes ☐ No ☐
Do you have concerns regarding sexual activity that you would like to discuss?	Yes ☐ No ☐

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Gynecologic History		
Have you ever been treated for:		Have you ever had any of the following:
❏ Sexually transmitted infection ❏ Abnormal Pap smear ❏ Recurrent vaginal infection ❏ Endometriosis ❏ Infertility ❏ Other:	Year:_________ Year:_________ Year:_________ Year:_________ Year:_________ Year:_________	❏ D&C ❏ Hysteroscopy ❏ Infertility surgery ❏ Laparoscopy ❏ Hysterectomy ❏ Fibroid removal ❏ Ovarian surgery ❏ Vaginal surgery

Medical and Surgical History	Check all that apply:
❏ Migraines ❏ Seizures ❏ Thyroid disorders ❏ Hepatitis ❏ Bowel disorders ❏ Bladder disorders ❏ Arthritis ❏ Cancer:_____________________ ❏ Other: ______________________	❏ Appendectomy ❏ Bowel surgery ❏ Gallbladder surgery ❏ Bladder surgery ❏ Heart surgery ❏ Joint or bone surgery ❏ Breast surgery ❏ Ear, nose, throat surgery ❏ Other: ____________________

Current Medications

Drug allergies:	Do you smoke? Yes ☐ No ☐ If so, number of cigarettes or packs/day:_____________
Food allergies:	Do you drink alcohol? Yes ☐ No ☐ If so, number of drinks per week:___________________

Family History	Does anyone in your family have or has had in the past:
❏ Diabetes ❏ High blood pressure ❏ Blood clots in lungs or legs ❏ Heart disease	❏ Cancer:_________________ ❏ Other serious medical problems: ❏
Have You Had Recently	
❏ Weight loss or gain ❏ Change in bowel function ❏ Change in bladder function ❏ Breast discharge ❏ Abnormal hair growth	❏ Change in energy ❏ Change in stress ❏ Change in skin ❏ Hot flushes ❏ Change in appetite