NORTHERN HEALTH CENTERS

OB/GYN History Form

PATIENT NAME: _____DOB:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Marital Status: ☐ S ☐ M ☐ D ☐ W You may call me at work ____Yes ____No

IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE EXPLAIN ON THE LINES BELOW

Who is your Primary Care Provider?		
Have you ever been hospitalized or had a major operation? If yes, please list type of operation and date.	Y N	
Do you use tobacco?	Y N	
If yes, are you ready to quit?	Y N	
Do your use controlled substances?	Y N	
Do you drink alcohol?	Y N	
If yes, no# of drinks per week		
Do you exercise regularly?	Y N	
Would you describe any of your personal relationships as violent?	Y N	

MEDICATION LIST: It is very important we have a list of ALL of your medications to properly treat you; including vitamins, supplements and herbal remedies. Please use an additional sheet if needed.

_____ _____
_____ _____
_____ _____

Are you allergic to any of the following?

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Latex** ☐ **Local Anesthetics** ☐ **Other Allergies**

Please explain:

_____

(PLEASE CIRLE YES OR NO to each question)

PREGANANCY HISTORY

Do you think you are pregnant now? ..... Y N
Total number of pregnancy's..... _____
Number of live births..... _____
Number of living children..... _____
Number of stillbirths..... _____
Number of premature births..... _____
Number of miscarriages..... _____
Number of induced abortions..... _____
Number of vaginal births..... _____
Number of caesarean births..... _____
Have you ever had gestational diabetes?..... Y N
Have you ever had an ectopic (tubal) pregnancy?..... Y N
Any other pregnancy complications? ..... Y N
Are you planning pregnancy in the next 12 months?..... Y N

HEALTH HISTORY

Are you currently sexually active?..... Y N
Are you currently using birth control?..... Y N
If yes, which method:_____
Have you had a hysterectomy?..... Y N
If yes, list indicate the date:_____
First day of most recent period __/__/__
How many days do you bleed?..... _____
Is your bleeding____light____med.___heavy
Unusual or missed periods in past year?..... Y N
Severe menstrual cramps?..... Y N
Premenstrual discomfort?..... Y N
When was your last mammogram?.....
When:_____Where:_____
When was your last colonoscopy?.....
When:_____Where:_____
Date of last eye exam: ____/_____/_____
Date of last dental exam: ____/____/_____
Do you currently have:
Breast lump or pain?..... Y N
Pain or burning with urination?..... Y N
Unusual vaginal discharge/odor?..... Y N
Vaginal itching/rash/bumps?..... Y N
Pain/bleeding with intercourse?..... Y N

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PAST MEDICAL HISTORY

IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE EXPLAIN ON THE LINES BELOW

Have you had:		**Comments**
Unexplained weight loss	Y N	
Migraine headache	Y N	
Cancer	Y N	
A history of thyroid problems(goiter)	Y N	
Diabetes (including while pregnant)	Y N	
Heart problems	Y N	
Breathing problems	Y N	
High blood pressure	Y N	
Blood clot to leg or lung	Y N	
Liver problems	Y N	
Blood with bowel movements	Y N	
Emotional problems/depression	Y N	
Breast biopsy	Y N	
Abnormal pap smear	Y N	When:
History of infection in uterus/tubes/ovaries	Y N	
Uterine fibroids	Y N	
History of gonorrhea/Chlamydia	Y N	
History of genital warts	Y N	
History of genital herpes	Y N	

YOUR FAMILY HISTORY, Have your grandparents, parents, or siblings ever had any of the following?

		If answered yes, please indicate which family member
Heart attack/stroke	Y N	
High blood pressure	Y N	
Diabetes	Y N	
High Cholesterol	Y N	
Breast cancer	Y N	
Ovarian cancer	Y N	
Colon cancer	Y N	
Blood clotting problems	Y N	
Thyroid problems	Y N	
Osteoporosis	Y N	
Other	Y N	

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