CENTRAL CAROLINA OB/GYN HEALTH HISTORY FORM
Division of Piedmont Healthcare for Women, P.A.

DATE________________

Name____________________________________ ID #_______________ DOB ________________

Allergies____

Religion________________________________ Ethnicity/Race______________________________

Occupation____

Who is your medical or family doctor?__________________________________

Problems or concerns?

____

____

____

How long has this been a problem?____

What have you tried for this?____

Did it help?__________________________

WOMAN'S HEALTH HISTORY

A. Menstrual cycle:

Age at first period?_________________ How often are your periods?_____________________

How long do your periods last?______________________

What was the first day of your last period?__________________________

Any problems with your period? Such as: very heavy flow, irregular periods, bleeding between your periods, bad cramps, other – please list____

____

B. Sexual History:

Sexual preference? Male_______ Female_______

Number of sexual partners in your lifetime? (circle) 0-2 3-5 >5

Are you currently sexually active?____________

C. Pap Smears:

Have you ever had an abnormal Pap smear?__________ If so, when?_____________

What was done for it?____

When was your last Pap smear?_______________ Was it normal?___________________________

D. Gyn Infections/Surgeries:

Have you ever had any of the following?

Yeast__________________
Bacterial_______________
Trichomonas____________
Chlamydia______________
Gonorrhea______________
Warts (HPV)____________
Herpes_________________
Syphillis_______________

D & C____________________________
Laparoscopy______________________
C-section________________________
Myomectomy______________________
Hysterectomy_____________________
Tubes tied_______________________
Ectopic or tubal pregnancy__________
Ovarian cyst_____________________
Other___________________________

E. Birth Control:

What are you using for birth control? Circle all that apply.

Abstinence Condoms Female condom Diaphragm IUD Contraceptive film

Spermicidal foam Spermicidal jelly Norplant DepoProvera Birth control Pills

Bilateral tubal ligation Vasectomy Withdrawal

Are you satisfied with your current method?____

If you stopped using birth control in order to get pregnant, when did you stop?_____________

F. Other GYN or female problems:

Breast lumps?________________
Have you ever had a Mammogram? ________ When was your last one?__________ Results?_______
Do you have discharge from your breasts?__________________

Fibroids?____________

Abnormalities of uterus or cervix?______________________

Pain with intercourse?_________________________________

Did your mother take DES when pregnant with you?___________________________________

Infertility?_______________ If so, what if any treatment?___________________________________

G. Pregnancy History

How many times have you been pregnant?_________ How many living children do you have?_______

How many fullterm deliveries?________ How many preterm deliveries?_______

How many miscarriages?____________ How many abortions? ______________

How many if any stillbirths?_________ Any twins? ______________________

Any problems with previous pregnancies such as the following?

Low iron — diabetes of pregnancy — heavy bleeding — vomiting severely

Incompetant cervix — too much or too little water around your baby

Depression after delivery — high blood pressure during pregnancy — preterm labor

Rh negative blood — Group B Strep

Other (please list)____

H. Preconceptual/Genetic History

Have you or your partner or either of your families had any of the following?

Cerebral Palsy_________ — Cleft lip or Palate__________
Birth defects___________ — Heart defects______________
Cystic fibrosis___________ — Downs syndrome__________
Hemophilia___________ — Huntington's Chorea_________
Mental retardation________ — Muscular dystrophy_________
Spina Bifida or NTD's_______ — Sickle cell trait or disease________
Tay Sach's Disease_________ — Test for Fragile X____________
Thalassemia A or B _________
Are you in any way blood related to your partner?___________
Other____

Partner's ethnic background?____
Partner's age_____________

Environmental risks:

Do you have cat?____________________________

Any chemical exposures?___________________

Do you smoke?__________ If so, how much?_____________ For how long?___________

Any second-hand smoke exposure?___________________

Do you drink any alcoholic beverages?(beer, wine, wine-coolers, liquor etc)________________

If yes, how much in a week on average?____

Any other recreational drug use?____

I. General Medical History

Have you or any of your close blood relatives had any of the following?

	Pt	Family		Pt	Family
Heart disease	_____	_____	Rheumatic fever	____	_____
Mitral valve prolapse	____	_____	High blood pressure	____	_____
Varicose veins	___	_____	Blood clots	____	_____
Bleeding disorders	___	_____	Low iron	____	_____
Sickle cell trait	___	_____	Blood transfusion	____	_____
Asthma	___	_____	Tuberculosis	____	_____
Emphysema	___	_____	Diabetes	____	_____
Thyroid Disease	___	_____	Bladder infections	____	_____
Kidney infections	___	_____	Kidney problems	____	_____
Leaking of urine	___	_____	Seizures	____	_____
Epilepsy	___	_____	Migraines	____	_____
Frequent headaches	___	_____	Strokes	____	_____
Cancer	___	_____	Mental/emotional probs	____	_____
Intestinal problems (hernia, irritable bowel, ulcers, Crohn's disease, etc)	___	_____	Liver problems (cirrhosis, hepatitis,etc)	____	_____
Auto immune disease (sarcoidosis, lupus, rheumatoid arthritis, etc.)	___	_____	Scoliosis	____	_____
			Joint problems	____	_____

Have you ever had any of the following?

Chicken pox?_____ Measles?_______
Mumps?______ Rubella?_______
HIV?________

Do you have any of the following?

Vision problems(do you wear glasses or contact lenses?)__________
Hearing problems?__________
Dental problems?___________

Have you ever been the victim of emotional or physical abuse in the past or currently?_________

Have you ever had any major accidents(broken bones, auto accidents, etc)?__________________

Any surgeries(wisdom teeth, appendix, tonsils etc)? Please list____

____

Any anesthesia problems?____

What medications if any do you take regularly?____
____

J. Lifestyle:

Exercise – Regular – Occasional – Rare Self Breast Exams – monthly – occasional – rare
Diet: Regular - Vegetarian. If vegetarian, what kind of vegetarian___________________________