generations ObGyn

Name: **DOB:**

Date:

PAST MEDICAL HISTORY

Yes	No		Date
		No Medical Illness	
		Anemia	
		Anxiety	
		Asthma	
		Bladder Problems-Leak or Drop	
		Blood Clots-Hypercoaguable Disease	
		Breast Cancer	
		Breast Disease-Cyst, Fibrocystic	
		Coronary Artery Disease	
		Deep Vein Thrombosis (DVT)	
		Depression	
		Diabetes	
		Diverticulosis of Colon	
		Epilepsy or Seizure	
		Gall Bladder Disease	
		Gastroesophageal Reflux	
		Glaucoma	
		Hepatitis-Any	
		High Blood Pressure	
		High Cholesterol	
		High Thyroid	
		Human Immunodeficiency Virus (HIV)	
		Irritable Bowel Syndrome	
		Kidney Calculus-Stones	
		Low Thyroid	
		Migraine	
		Mitral Valve Prolapse-Heart	
		Neurologic Disease	
		Osteopenia	
		Osteoporosis	
		Peptic Ulcer Disease	
		Previous Blood Transfusion	
		Pulmonary Embolism	
		Sickle Cell Anemia	
		Stroke	
		Urinary Tract Infection	

Immunity

	Ever had chicken pox or vaccine?	Yes	No	Don't know
	Rubella vaccine or test as adult?	Yes	No	Don't know
	Gardasil Vaccine?	Yes	No	Don't know
	Influenza Vaccine?	Yes	No	Don't know
	Tdap Vaccine?	Yes	No	Don't know

SOCIAL HISTORY

- Smoke? Tobacco ☐ Marijuana ☐
- Drink? Alcohol ☐ Caffeine ☐
- Drug Abuse? Nonprescription ☐ Prescription ☐
- Wear Seat Belt? Yes ☐ No ☐
- Diet? Calcium ☐ Iron ☐
- Exercise? Daily ☐ 2-3x week ☐ Never ☐
- Domestic Violence? Past ☐ Present ☐
- Married ☐ Single ☐
- Occupation:

MEDICATIONS (Vitamins, Herbal / Alternative Meds)

Current Medication	Prescribing Doctor

PAST SURGICAL HISTORY

Surgery	Date

PREGNANCY HISTORY

Total Number of Pregnancies		
Full Term Pregnancies		
Premature Pregnancies		
Number of Miscarriages/Abortions		
Living Children		
Type of Delivery(s)		
Vaginal	C/Section	Biggest Baby

GYNECOLOGIC HISTORY

Yes	No		Date
		Abnormal PAP Smear	
		Abnormal Bleeding/Irregular Bleeding	
		Bladder Problems, Leak, Frequency, Urgency?	
		Endometriosis	
		Infertility	
		Painful Sex	
		Pelvic Floor Relaxation, Prolapse	
		Pelvic Inflammatory Disease	
		Pelvic Pain	
		PMS	
		Sexually Transmitted Disease, if Yes, Type	
		Sexual Arousal, Libido Disorder?	

MENSTRUAL HISTORY

Age Started Period	
Last Menstrual Period	
How Often?	
How Long?	
Menopause, if Yes, What Age?	
Sexually Active, Birth Control?	

FAMILY MEDICAL HISTORY

Yes	No	Disease Name	Relative / Age
		Adopted	
		Cancer (Breast,Colon,Ovarian,etc)	
		Clotting Disorder	
		Diabetes	
		Heart Disease	
		High Blood Pressure	
		High Cholesterol	
		Infertility	
		Osteoporosis	
		Stroke	
		Thyroid Disease	

SCREENING TEST

	Screening Test	Date	Never
	Colonoscopy		☐
	Dexa Scan		☐
	HPV Testing		☐
	Mammogram		☐
	Pap Smear		☐

ALLERGIES & REACTIONS

Allergy	Reaction