

Name: _____

Age: _____ Date: _____

OBSTETRICAL HISTORY

Total number of times pregnant _____

How many full term babies have you had? _____

How many premature babies have you had? _____

How many miscarriages have you had? _____

Have you ever had an abortion? _____ How many? _____ When? _____

Complications? _____

How many sets of twins have you had? _____

Have you ever had an ectopic (tubal) pregnancy? _____ How many? _____

How many living children do you have? _____

Have you ever had a cesarean section? _____ How many? _____

What was the reason for the first one? _____

Were any of your pregnancies complicated? _____ By high blood pressure? _____ Hemorrhage _____

RH disease _____ Any other reason? _____

Were you ever hospitalized before labor? _____ Why? _____

What was the weight of your largest baby? _____

How old is your oldest child? _____ How old is your youngest child? _____

GYNECOLOGICAL HISTORY

Do you menstruate? _____ When did you last menstrual period start? (DATE) _____

Menstruated first time at what age _____

If not menstruating, stopped at age _____

Have you had any bleeding or spotting since menstruation stopped? _____

How often do you have your periods? Every _____ days

Menstrual flow usually lasts for a total of _____ days.

How many pads or tampons do you use on your heaviest day? _____

Do you usually have clots with your periods? _____

Are your periods usually painful? _____ If so, MILD, MODERATE, SEVERE, INCAPACITATING (circle one)

Do you ever have bleeding or spotting between periods? _____

Do you ever have bleeding or spotting after intercourse? _____

Have you ever had a pap smear? _____ When? _____ Where? _____ Normal? _____

If over 35 years old, when was your last mammogram? _____

Have you ever been treated for venereal disease? _____ If so, what kind? _____

Have you ever been treated for herpes of the genitalia? _____

GYNECOLOGICAL HISTORY continued

Have you ever been treated for vaginal warts? _____

Have you ever had problems with **chronic** vaginitis? _____

Are you presently using a form of contraception? _____ If so, circle method used:

Pills – Brand _____ How long? _____

IUD - Brand _____ How long? _____

Diaphragm Condoms Rhythm Withdrawal Tubal Ligation Vasectomy Foam Sponge

Are you satisfied with you method of birth control? _____

PAST HISTORY

Have you ever had an operation on any of the following?

	YEAR		YEAR
Appendix	_____	Breast	_____
Gall Bladder	_____	Ovary	_____
Kidney Stones	_____	Fallopian Tubes	_____
Tonsils	_____	Womb or Uterus	_____
Tumor of any kind	_____	Vaginal Repair	_____
Varicose Veins	_____	Cesarean Section	_____
Hernia	_____	D & C	_____
Hemorrhoids	_____	Cryo Surgery of Cervix	_____
Chest	_____	Laparoscopy	_____
Spine	_____	Other Surgery	_____

Other then for surgery, have you ever been hospitalized? _____ Why? _____

Have you ever had a blood transfusion? _____ Any adverse reaction? _____

Did your mother take hormones during her pregnancy with you? _____

Are you allergic to any drugs? _____ If so, what? _____

What medications are you presently taking? _____

What is the main reason for your appointment today? _____

REVIEW OF SYSTEMS

INFETIOUS DISEASE RECORD

Year or approximate age

Have you ever had: German measles _____
Poliomyelitis _____
Tuberculosis _____

HEENT

Any problems with: Ears _____
Eyes _____
Nose _____
Throat _____
Headaches _____

RESPIRATORY

Have you ever had: Pneumonia _____
Asthma _____

Have you coughed up blood? _____

CARDIAC

Have you had: Heart problems or murmur _____
Shortness of breath _____

GASTROINTESTINAL

Ever had: Hepatitis _____
Liver disease _____
Yellow jaundice _____
Gallbladder disease _____
Stomach ulcer _____
Chronic constipation/diarrhea _____
Blood in stools _____
Other problems with digestive system _____

KIDNEY

Have you ever had: A kidney infection _____
A bladder infection _____
Blood or pus in urine _____
Kidney stones _____

ENDOCRINE

Have you ever had: Diabetes _____
Thyroid problems _____

EXTREMITIES

Any problems with: Veins in your legs _____
Muscles _____
Joints _____

BLOOD

Ever been anemic? _____
Had a blood transfusion? _____

