Women For Women OBGYN
New Obstetrical Patient

Name: _____
Date of Birth: _____
Date: _____

Are you taking any medications? ☐ yes ☐ no

If yes, please list the medications (including over the counter medications, supplements, vitamins):

_____
_____
_____
_____
_____
_____
_____

Do you have any allergies? ☐ yes ☐ no

If yes, please list allergy and type of reaction:

_____
_____
_____
_____
_____
_____
_____

Gynecologic History:

Date of last period? _____

Age at first period? _____ If menopausal, age at last period? _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

How many current sexual partners do you have?

How many sexual partners have you had in your lifetime?

Do you have sex with ☐ men ☐ women ☐both

Have you ever had any of the following?

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Syphillis
- ☐ HIV
- ☐ HPV/Genital Warts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Infertility

Last Pap smear _____

Last Mammogram _____

Last colonoscopy _____

Last bone density _____

Any abnormal Pap smears?

If yes, any treatment?

- ☐ LEEP/Cone biopsy
- ☐ Laser
- ☐ Cryo (freezing)

Have you completed the HPV/Gardasil Vaccine series? ☐ yes ☐ no

Have you had the Hepatitis B vaccine series? ☐ yes ☐ no

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Obstetrical History:

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies.

Birthdate	Type of Delivery	# of weeks	Sex	Baby weight	Epidural?	Complications	Place of delivery

Is this pregnancy a result of fertility treatments? ☐ yes ☐ no

Have you had the chicken pox or shingles? ☐ yes ☐ no

Have you been vaccinated against the chicken pox? ☐ yes ☐ no

Have you ever been exposed to Tuberculosis? ☐ yes ☐ no

Have you ever had Parvovirus (also known as fifth disease)? ☐ yes ☐ no

Do you work with children? ☐ yes ☐ no

Is there a family or personal history of:

☐ Thalassemia?
☐ Neural Tube Defect?
☐ Down Syndrome?
☐ Tay-Sachs Disease?
☐ Sickle Cell Disease or Trait?
☐ Hemophilia?
☐ Muscular Dystrophy?
☐ Cystic Fibrosis?
☐ Huntington's Disease?
☐ Mental Retardation?
☐ Fragile X?
☐ Other Genetic diseases?
☐ Birth Defects?
☐ more than 3 miscarriages?
☐ stillbirth?
☐ congenital heart defect?

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Past Medical History:

Do you have now, or have you ever had:

- ☐ Asthma/Lung Disease
- ☐ Anemia (low blood count)
- ☐ Autoimmune disorder (Lupus, Rheumatoid Arthritis, Sjogrens)
- ☐ Bleeding Disorder
- ☐ Bone/Joint Disease
- ☐ Blood transfusion
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Leukemia/Lymphoma
- ☐ Other Cancer
- ☐ Diabetes
- ☐ Blood clots
- ☐ Depression/Anxiety
- ☐ Elevated cholesterol
- ☐ Gastrointestinal illness
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack
- ☐ Migraines
- ☐ Osteoporosis/Osteopenia
- ☐ Stroke/TIA
- ☐ Thyroid
- ☐ Trauma
- ☐ Tuberculosis
- ☐ Other: _____

_____

Past Surgical History:

Please mark any surgical procedure you have had:

- ☐ Dilation and curettage (D&C)
- ☐ Tubal Ligation
- ☐ Hysterectomy
- ☐ Removal of one or both ovaries
- ☐ Appendectomy
- ☐ Breast surgery (biopsy, lumpectomy, mastectomy)
- ☐ Breast Plastic Surgery
- ☐ Tummy tuck
- ☐ Cholecystectomy (removal of gallbladder)
- ☐ Hernia Repair
- ☐ Hip Surgery
- ☐ Knee surgery
- ☐ Tonsilectomy
- ☐ Thyroid surgery
- ☐ Spine surgery
- ☐ Cesarean Section
- ☐ Other _____

_____

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Family History:

Illness	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other Relative
Breast Cancer									
Colon Cancer									
Ovarian Cancer									
Uterine Cancer									
Heart Disease/ Heart Attack									
High Blood Pressure									
Stroke									
Blood Clot									
Diabetes									
Other									

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Social History:

Tobacco Use: ☐ never ☐Current ____#of cigarettes per day ____#of years ☐ Former, year quit _____

Any Alcohol use? ☐ yes ☐ no If yes, average # of drinks per week? _____

Do you used recreational drugs? ☐ yes ☐ no If yes, what type and when was last use?

_____

How many times per week do you exercise? _____

Any history of violence or abuse in your current household, or in the past? ☐ yes ☐ no

What do you do for a living? _____

Who do you live with? _____

If it were medically necessary, would you accept a blood transfusion? ☐ yes ☐ no

Review of Systems:

Please check any symptoms you are currently experiencing:

☐ Fatigue	☐ Chest Pain	☐ Pain with urination
☐ Unexplained weight loss	☐ Shortness of breath	☐ Leakage of urine
☐ Unexplained weight gain	☐ Nausea/Vomiting	☐ Painful intercourse
☐ Fever	☐ Leg swelling	☐ Bleeding after intercourse
☐ Breast mass	☐ Frequent headaches	☐ Bleeding between periods
☐ Breast discharge	☐ Bleeding from rectum	☐ Vaginal itch
☐ Easy bruising	☐ Blood in urine	☐ Constipation

Signature of patient: _____