COLLEGE HILL
Obstetrics and Gynecology

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PATIENT HISTORY

DOCTORS REQUIRE THIS FORM TO BE COMPLETELY FILLED OUT EVERY 3 YEARS

NAME:	**DATE**:

Welcome:

Your accurate completion of this health history is greatly appreciated. This will allow us to more accurately address your health problems and make recommendations. This information enables us to spend more quality time evaluating your present concerns and less time on the collection process of your previous health history. Please let us know if you have any questions and thank you for your assistance.

DATE OF BIRTH: _____ AGE: _____

PROBLEMS: PLEASE CHECK ALL THAT APPLY

- ☐ STD
- ☐ BREAST LUMP
- ☐ VAGINAL DISCHARGE
- ☐ PAINFUL PERIODS
- ☐ LACK OF PERIODS
- ☐ IRREGULAR PERIODS
- ☐ ABNORMAL UTERINE BLEEDING
- ☐ PREGNANCY
- ☐ VAGINAL ITCHING
- ☐ ABNORMAL CERVICAL PAPSMEAR
- ☐ INFERTILITY
- ☐ BIRTH CONTROL
- ☐ SURGERY CONSULTATION
- ☐ PELVIC/ABDOMINAL PAIN
- ☐ CYST/ FIBROIDS
- ☐ MENOPAUSE/ HORMONES
- ☐ OTHER_____

SURGICAL HISTORY: PLEASE LIST ALL SURGERY YOU HAVE HAD AND APPROXIMATE DATES:

a._____

b._____

c._____

d._____

PRIMARY CARE PROVIDER:_____

PREFERRED PHARMACY: _____

MEDICATIONS: PLEASE LIST ANY CURRENT MEDICATIONS THAT YOU ARE TAKING (INCLUDING HERBAL & OVER THE COUNTER) _____

VACCINES: PLEASE LIST ALL RECENT VACCINATIONS THAT YOU HAVE RECEIVED

_____

ALLERGIES: PLEASE LIST ANY ALLERGIES TO MEDICATIONS/FOOD (LATEX OR IODINE)

_____

PAST MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

- ☐ DOMESTIC VIOLENCE_____
- ☐ ACID REFLUX_____
- ☐ ANEMIA_____
- ☐ ANESTHESIA COMPLICATIONS_____
- ☐ ARTHRITIS_____
- ☐ ASTHMA_____
- ☐ BIRTH DEFEFECTS OR INHERITED DISEASE_____
- ☐ BLOOD TRANSFUSION_____
- ☐ BREAST CANCER_____
- ☐ BREAST PROBLEM_____
- ☐ CANCER_____
- ☐ DEPRESSION_____
- ☐ DIABETES_____
- ☐ EATING DISORDER_____
- ☐ ECZEMA_____
- ☐ ENDOMETRIOSIS_____
- ☐ FIBROMYALGIA_____
- ☐ GI PROBLEMS_____
- ☐ HEADACHES_____
- ☐ HEART DISEASE_____
- ☐ HEART PROBLEMS_____
- ☐ HEPATITIS_____
- ☐ HIGH CHOLESTEROL_____
- ☐ HYPERTENSION_____
- ☐ INFERTILITY_____
- ☐ KIDNEY DISEASE_____
- ☐ KIDNEY OR BLADDER PROBLEMS_____
- ☐ LUNG DISEASE_____
- ☐ OSTEOPOROSIS_____
- ☐ OTHER_____
- ☐ OVARIAN CANCER_____
- ☐ POLYPS_____
- ☐ PRE-ECLAMPISA_____
- ☐ PSYCHIATRIC ILLNESS_____
- ☐ STROKE_____
- ☐ THROMBOPHILIAS_____
- ☐ THYROID PROBLEMS_____
- ☐ VARICOSTIES_____

SOCIAL HISTORY:

a. CIGARETTE SMOKING: YES / NO AMOUNT: _____

b. TOBACCO YEARS OF USE_____

c. FREQUENCY OF ALCOHOL USE: _____

d. HISTORY OF ANY DRUG USE: _____

e. OCCUPATION OR TYPE OF EMPLOYMENT: _____

FAMILY HISTORY: PLEASE LIST ANY FAMILY MEMBERS WITH THE FOLLOWING ILLNESSES (PARENTS, GRANDPARENTS, AUNTS OR UNCLES) PATERNAL / MATERNAL (?)

HEART DISEASE: _____	TUBERCULOSIS: _____	STROKE: _____
HIGH BLOOD PRESSURE: _____	BREAST CANCER: _____	KIDNEY DISEASE: _____
DIABETES: _____	COLON CANCER: _____	OSTEOPOROSIS: _____
CANCER: _____	OVARIAN CANCER: _____	THYROID DISORDER: _____

GYNECOLGY HISTORY:

DATE OF LAST PAP SMEAR:

_____RESULT_____?

HPV VACCINE: _____

SEXUALLY ACTIVE? _____

SEXUAL PROBLEMS? _____

STIs/STDs: _____

DATE OF MOST RECENT MAMMOGRAM: _____

AGE AT FIRST CHILD: _____

CURRENT BIRTH CONTROL METHOD: _____

DESIRED BIRTH CONTROL METHOD: _____

ABNORMAL PAP: YES / NO

LAST MENSTRUAL PERIOD: _____

HOW MANY DAYS DO YOU FLOW? _____

ARE YOUR FLOWS LIGHT OR HEAVY? _____

FREQUENCY OF CYCLE: _____

AGE THAT YOU STARTED YOUR MENSTRUAL CYCLE: _____

IF POST MENOPAUSAL, AGE AT MENOPAUSE: _____

PRENATAL HISTORY:

TOTAL PREGNANCIES: ___TOTAL MISCARRIAGES: ____TOTAL ABORTIONS: _____ CHILDREN LIVING_____ECTOPIC PREG: ____

BIRTH DATE SEX WEIGHT TYPE OF DELIVERY COMPLICATION LOCATION

_____

_____

_____

_____

_____

Any history of MRSA? If yes, when? Have you tested negative since your positive test of MRSA?

_____

_____

REVIEW OF SYMPTOMS: ARE YOU PRESENTLY HAVING ANY OF THESE PROBLEMS?

- ☐ CHEST PAIN, SHORTNESS OF BREATH, IRREGULAR HEART RATE
- ☐ COUGHING UP OF SPUTUM, BLOOD OR WHEEZING
- ☐ BREAST PAIN, NIPPLE DISCHARGE OR BLEEDING
- ☐ ABDOMINAL PAIN
- ☐ BLACK, TARRY STOOLS, BLOOD OR MUCUS IN STOOLS
- ☐ PERSISTENT DIARRHEA OR CONSTIPATION
- ☐ PAIN OR SWELLILNG OF JOINTS
- ☐ BURNING WITH URINATION, BLOOD IN URINE OR UNUSUAL URINARY FREQUENCY
- ☐ INVOLUNTARY LOSS OF URINE
- ☐ VAGINAL DISCHARGE, BURNING OR ITCHING
- ☐ PAINFUL INTERCOURSE
- ☐ PELVIC PAIN

QUESTIONS?_____

_____