OBSTETRICS-GYNECOLOGY Department
Patient History Form

Name: ______________________________
Age: ______________________________
Home Phone: ______________________________
Work Phone: ______________________________

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE: Date: ____________________
Reason for Appointment:
____
____

Referring Physician: ______________________ Primary Physician: ______________________

MEDICATIONS:

List the NAMES (and DOSE if known) of the medicine you take every day (including non-prescription medicines):

Allergies (please list): ____

PAST SURGICAL OR HOSPITALIZATION HISTORY:

List all of the surgeries or hospitalizations you have ever had:

SOCIAL HISTORY:

Do you use tobacco? ☐ Yes ☐ No If yes: Quantity: __________ How Long: __________ Quit (when): __________

Do you drink alcohol? ☐ Yes ☐ No If yes: How many drinks per day, week, etc.? ____________________

Do you drink caffeinated drinks? ☐ Yes ☐ No If yes: How many? Colas __________ Coffee __________ Tea __________

PAST PERSONAL & FAMILY HISTORY:

Please write “Y” (Yes) or “N” (No) under SELF if you have had any of the listed conditions.
Please write “Y” (Yes) or “N” (No) under FM if a family member has had any of the listed conditions.

Condition	SELF	FM
Anemia		
Arthritis		
Asthma		
Bleeding Tendency		
Cancer		
Chicken Pox		
Cholesterol		
Depression		
Diabetes		

Condition	SELF	FM
Glaucoma		
Heart Problems		
Hepatitis		
HIV/AIDS		
High Blood Pressure		
Hoarseness		
Immune Disease		
Kidney Disease		
Liver Disease		

Condition	SELF	FM
Lung Disease		
Seizures		
Sexually Transmitted Diseases		
Shortness of Breath		
Stroke		
Thyroid Problems		
Trouble with Anesthesia		

If you have had a condition not listed above, please describe here: ______________________________
____
____

Please complete other side of form.

MENSTRUAL HISTORY:

First day of last menstrual period? ___________

Are periods regular? ___________

At what age did you start having menstrual periods? ___________

What type of birth control? ___________

When did you last have a pap smear? ___________

Total number of pregnancies? ___________

Number of live births? ___________

Number of miscarriages? ___________

If you have gone through the change (menopause), have you had bleeding since then? ___________

When was your last mammogram? ___________

REVIEW OF SYSTEMS: (Please ✔ yes or no to each area if you currently have any of the conditions below.)

CONSTITUTIONAL SYMPTOMS	**NO**	**YES**
Good General Health Lately		
Recent Weight Change		
Fatigue		
EYES		
Blindness (Which Eye) _____ or both		
Blurred or Double Vision		
EARS/NOSE/MOUTH/THROAT		
Hoarseness		
Nosebleeds		
CARDIOVASCULAR		
Heart Murmur (Ever)		
Heart Trouble		
Chest Pain or Pressure		
Palpitation		
Shortness of Breath		
Swelling of Feet, Ankles, Hands		
Enlarged or Varicose Veins		
RESPIRATORY		
Spitting Up Blood		
Shortness of Breath		
GENITOURINARY		
Kidney or Bladder Infection		
Kidney or Bladder Stone		
Bloody Urine		
Gallbladder Trouble		
Menstrual Problems		
Any Urine Loss		
Sexual Problems		

GASTROINTESTINAL	**NO**	**YES**
Blood in Stool		
Frequent Constipation		
Frequent Diarrhea		
Frequent Heartburn or Indigestion		
Hemorrhoids or Rectal Disease		
Loss of Appetite		
Nausea or Vomiting		
Recurrent Abdominal Pain		
Stomach/Intestinal Ulcer		
Vomiting Blood		
MUSCULOSKELETAL		
Arthritis		
Leg Cramps at Exercise or Rest		
Leg Fatigue with Walking/Exercise		
INTEGUMENTARY		
Eczema, Hives, Fungus, Rash		
NEUROLOGICAL		
Numbness or Weakness or Tremors		
Frequent or Recurring Headaches		
Light-Headed or Dizzy		
ENDOCRINE		
Thyroid Disease		
Diabetes		
OTHER		
Anxiety		
Depression		

Patient Signature Date

Physician Signature Date

Form Reviewed:

Date					
Initials					