Ob-Gyn Specialists
A division of Women's Health Partners of California Inc
women caring for women

Patient's Name: _____ Patient's DOB: _____

Patient History

Medical History		**Date**(s)	**Details**
Abnormal Pap	[ ] YES [ ] NO		
Anemia	[ ] YES [ ] NO		
Anesthetic Complications	[ ] YES [ ] NO		
Asthma	[ ] YES [ ] NO		
Bleeding Disorder	[ ] YES [ ] NO		
Breast Problems	[ ] YES [ ] NO		
Coronary Artery Disease	[ ] YES [ ] NO		
Depression/Anxiety	[ ] YES [ ] NO		
Diabetes	[ ] YES [ ] NO		
Herpes	[ ] YES [ ] NO		
HIV/AIDS	[ ] YES [ ] NO		
Hypertension	[ ] YES [ ] NO		
Infertility	[ ] YES [ ] NO		
Kidney Disease	[ ] YES [ ] NO		
Liver Disease	[ ] YES [ ] NO		
Lupus	[ ] YES [ ] NO		
Postpartum Depression	[ ] YES [ ] NO		
Rh Incompatibility	[ ] YES [ ] NO		
Seizures	[ ] YES [ ] NO		
Sickle Cell Anemia	[ ] YES [ ] NO		
Thyroid Disease	[ ] YES [ ] NO		
Trauma / Violence	[ ] YES [ ] NO		
Varicosities / Phlebitis	[ ] YES [ ] NO		
Other			
Surgical History			
Abdomen Surgery	[ ] YES [ ] NO		
Appendectomy	[ ] YES [ ] NO		
Breast Enhancement	[ ] YES [ ] NO		
Breast Reduction	[ ] YES [ ] NO		
Cholecystectomy	[ ] YES [ ] NO		
C-Section	[ ] YES [ ] NO		
Endometrial Ablation	[ ] YES [ ] NO		
Exploratory Laparotomy	[ ] YES [ ] NO		
Fibroid Removal (myomectomy)	[ ] YES [ ] NO		
Genital Wart Removal	[ ] YES [ ] NO		
Gynecologic Cryosurgery	[ ] YES [ ] NO		
LEEP	[ ] YES [ ] NO		
Mastectomy	[ ] YES [ ] NO		
Weight Loss Surgery	[ ] YES [ ] NO		
Other			

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Family History **Relationship**	Status	Breast Cancer	Colon Cancer	Ovarian Cancer	Other Cancer	Diabetes	Eclampsia	Hypertension	Miscarriages	Preterm Labor	Stroke
Paternal Grand Father											
Paternal Grand Mother											
Maternal Grand Mother											
Maternal Grand Father											
Father											
Mother											
Brother											
Sister											
Other											

Social				
Alcohol Use [ ] YES [ ] NO	[ ] Glasses wine per week	[ ] Cans Beer per week	[ ] Shots of liquor per week	[ ] Drinks containing .5 oz. of alcohol per week

Tobacco use: packs per day	[ ] Never	[ ] ¼	[ ] ½	[ ] 1	[ ] 1 ½	[ ] 2	[ ] 3	[ ] Other
Tobacco use: # of years	[ ] ½	[ ] 1	[ ] 2	[ ] 3	[ ] 4	[ ] 5	[ ] 10	[ ] 15
Smokeless Tobacco	[ ] YES [ ] NO	Comment:						
Drug Use	[ ] YES [ ] NO	Comment:						

Drug Type: (please circle)				
	Amphetamines Amyl Nitrate/Poppers Anabolic Steroids Barbiturates Benzodiazepines 'Crack' Cocaine Cocaine Codeine	Fentanyl Flunitrazepam GHB Hashish Heroin Hydrocodone Hydromorphone Ketamine	LSD Marijuana MDMA (Ecstacy) Mescaline Methamphetamines Methaqualone Methylphenidate Morphine	Nitrous Oxide Opium Oxycodone PCP Psilocybin (Shrooms) Solvent Inhalants Other

Sexually Active	**Partners**	**Birth Control Protection**		
[ ] YES [ ] NO	[ ] Male [ ] Female	Abstinence Withdrawal (pull out) Birth Control Pills Condom Diaphragm Injection	IUD [ ]Mirena [ ] ParaGard [ ] Skyla Nexplanon NuvaRing Patch Post-Menopausal Rhythm (Natural Family Planning)	Spermicide Sponge Tubal Ligation Vasectomy Other None

Obstetrical History:

Please specify ALL pregnancies including any miscarriages, ectopic pregnancies, stillbirths and abortions)

Date(s) of Delivery	**C-section or Vaginal**	**Sex & Birth Weight**	**Anesthesia Type** Epidural, Spinal, Local, None, etc.	**Hospital Location**	**Physician**	**Complications** (e.g., Diabetes, Hypertension, PTL)

Menstrual History: LMP (mm/dd/yy) ------/------/------

Period Cycle	No of Days: _____	Menstrual Control / Protection	Panty Liner Thin Pad Maxi Pad	Hospital Pad Tampon Other
Period Duration	No of Days: _____		How frequently in HOURS do you change your protection? _____ times per hour.	
Period Pattern	[ ] Regular [ ] Irregular	Dysmenorrhea (cramps)	[ ] None [ ] Moderate	
Menstrual Flow	[ ] Light [ ] Moderate [ ] Heavy		[ ] Mild [ ] Severe	

Pharmacy

Name	**Street Address**	**City & Zip Code**

Medications/Supplements/Vitamins:

Name	**Dosage**	**Reason for Taking**

Medication Allergies

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

_____ _____

Patient's Signature Today's Date