# Williamsburg OB/GYN
# Health History Form

## PATIENT INFORMATION

**Name:** _____ **Today's Date:** _____
(First) (Middle) (Last/Maiden)

**Date of birth:** _____ (mm/dd/yyyy) **Birthplace:** _____
Single: ____ Married: ____ Divorced: ____ Separated: ____ Widowed: ____
How do you prefer to be addressed? (Miss – Ms – Mrs. - First name/nickname): _____

**Education:**
Years of High School _____ Years of College _____ Highest degree completed _____
**Occupation:** _____
**Place of employment:** _____
_____

## MENSTRUATION HISTORY

Age you began menstruation: _____ Start date of most recent menses: _____
- ❑ Regular
- ❑ Irregular

# of days from the first day of your period to the next: _____
**Duration of flow:** _____
**Pain with periods:**
- ❑ Yes
- ❑ No

***If yes, what do you do to relieve it? Please list:*** _____
_____

**Flow:**
Light to Moderate _____ Moderate to Heavy _____ Heavy to Very Heavy _____
**Are you menopausal?**
- ❑ Yes
- ❑ No

***If yes, are you taking hormones? Please list:*** _____
_____

**Do you experience any of the following?**
Hot Flashes ____ Insomnia ____ Moodiness ____ Vaginal Dryness/Irritation ____

## Present Method of Birth Control:

- ❑ Condoms
- ❑ Nexplanon
- ❑ Depo Provera
- ❑ NuvaRing
- ❑ IUD – _____ (name)
- ❑ Birth Control Pills – _____ (name)
- ❑ Tubal Ligation
- ❑ Rhythm Method (Natural Family Planning)
- ❑ Vasectomy
- ❑ Hysterectomy

**Date present method started:** _____
**Are you satisfied with your current method of birth control?** YES / NO
**Do you experience pain with intercourse?** YES / NO
**Are you satisfied with sex now?** YES / NO

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## PREGNANCY HISTORY

**Have you ever been pregnant?**
- ☐ Yes
- ☐ No

**Are you pregnant now?**
- ☐ Yes
- ☐ No

Date of most recent pregnancy: _____
-How many total pregnancies _____
-How many babies born term _____
-How many born before 37 weeks _____
-How many now living _____
-How many miscarriages, abortions, ectopic pregnancies, molar pregnancies _____
-How many vaginal deliveries _____
-How many C-sections _____
-How many vaginal births after C-section _____

**High blood pressure?**
- ☐ Yes
- ☐ No

**Pre-eclampsia?**
- ☐ Yes
- ☐ No

**Diabetes?**
- ☐ Yes
- ☐ No

***Other, please describe:*** _____

## FAMILY HISTORY

**Mother:**
Living? YES / NO Age: _____
Has your mother ever been diagnosed with Breast Cancer? YES / NO
Ovarian Cancer? YES / NO

Any other significant illness? _____

**Father:**
Living? YES / NO Age: _____

Significant illnesses? _____

## FAMILY HISTORY (continued..)

**Siblings:**
**Brother or Sister:**

**Age:** _____

**Significant Illness:** _____

Has a sister, grandmother or aunt ever been diagnosed with Breast or Ovarian Cancer?
- ☐ Yes
- ☐ No

## SOCIAL HISTORY

Do you smoke? YES / NO ***If yes, how much?*** _____

Do you drink alcohol? YES / NO ***If yes, how much?*** _____

Do you use recreational drugs? YES / NO ***If yes, how much?*** _____

Are you in an abusive relationship? YES / NO
Would you like us to discuss this issue with you or provide you with further information? YES / NO

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## PERSONAL MEDICAL HISTORY

**Prescription Medications from any provider:**

Name Dosage For what/How long?

**Over the counter medications/supplements:** _____

**Are you allergic to any medications?** YES / NO *If yes, please list:* _____

## ARE YOU EXPERIENCING ANY PROBLEMS WITH:

| | | *If yes, please describe?* |
|---|---|---|
| -Your eyes, ears, nose, throat | YES / NO | |
| -Your heart (pain, palpitations, etc..) | YES / NO | |
| -Your lungs (shortness of breath, cough) | YES / NO | |
| -Your stomach (pain nausea, bloating, etc..) | YES / NO | |
| -Your bowels (diarrhea, constipation, bleeding) | YES / NO | |
| -Headaches, migraines | YES / NO | |
| -Joint pain, muscle pain, back pain | YES / NO | |
| -Depression, anxiety | YES / NO | |
| -Eating disorders | YES / NO | |
| -Substance abuse | YES / NO | |
| -Urination | YES / NO | |
| -Involuntary loss of urine (when coughing or sneezing) | YES / NO | |

## THE FOLLOWING REPRESENT RISK FACTORS FOR AIDS (HIV)

-Multiple sex partners -I.V. drug abuse

-A sexual partner who is/was Bi-Sexual - A sexual partner who is/was an I.V. drug abuser

**Annual HIV testing is recommended. Would like to be tested?** YES / NO

## HAVE YOU EVER BEEN DIAGNOSED AND/OR TREATED FOR ANY OF THE FOLLOWING?

- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Chlamydia
- ❑ AIDS
- ❑ Hepatitis
- ❑ Condyloma
- ❑ Herpes
- ❑ Pelvic Inflammatory Disease/Infection

**Have you ever had an abnormal pap?**

- ❑ Yes
- ❑ No

**Have you had the Gardasil vaccine?**

- ❑ Yes
- ❑ No

*If yes to any of the following, please list date and treatment:* _____

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**PAST MEDICAL HISTORY**

| Date | Surgery/Hospitalized For |
| --- | --- |
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