Northwest Obstetrics & Gynecology Associates, Inc
H E A L T H H I S T O R Y

Date of Visit _____
Patient's Name _____
Preferred Name _____
Physician (OB/GYN) _____
Physician (Family/Internal)_____
Referred by ☐ Physician_____
☐ Family/Friend_____
☐ Other_____
☐ New Patient ☐ Current Patient

Reason for visit

_____
_____
_____
_____

Age _____

Pregnancy History

Number of times pregnant _____
Miscarriages _____
Ectopic _____
Abortions _____
Living children _____

Menstrual History

Age menses started_____
Regular monthly cycles ☐ Yes ☐ No
First day of last two menstrual periods
_____, _____
Current method of contraception _____
Are you sexually active ☐ Yes ☐ No
Previous STDs (sexually transmitted diseases)
_____
_____

Preventative Care

Date of last pap smear _____
Have you ever had an abnormal pap ☐ Yes ☐ No
When _____
Date of last mammogram _____
History of abnormal mammogram ☐ Yes ☐ No
Date of last Cholesterol test (if > 35 y) _____
Date of last colon cancer screening (> 50 y)_____
Date of last DEXA (bone scan) (> 50 y)_____
Vaccinations (year)
HPV series 1st _____ 2nd _____ 3rd _____
Measles, Mumps and Rubella (MMR)_____
Flu _____
Tetanus _____
Pneumococcus (>65y)_____

Current **Medical Problems/Illnesses**

_____
_____
_____

Surgeries/Injuries (include year if know)

_____
_____
_____

Allergies to drugs

_____
_____

Medications you are currently taking

_____
_____
_____

Social History

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered ☐
Smoker ☐ Yes ☐ No ☐ Former # of packs per day ____, how many years ____
Alcohol ☐ Yes ☐ No # of drinks per week _____
Have you ever used recreational/illegal drugs ☐ Yes ☐ No Type _____
Have you ever had a blood transfusion ☐ Yes ☐ No When _____
Occupation _____
Do you exercise regularly ☐ Yes ☐ No Hours per week _____

Family History -- Please place **F**=Father, **M**=Mother, **B**=Brother, **S**=Sister, **C**=Child, **MGM =** Maternal Grandmother, **MGF**= Maternal Grandfather, **PGM** = Paternal Grandmother, **PGF** = Paternal Grandfather next to any issue/problem.

Osteoporosis _____	Heart Disease _____
Diabetes_____	High Cholesterol _____
High Blood Pressure _____	Blood Clots _____
Stroke _____	Liver Disease _____
Breast Cancer _____	Genetic Disorder _____
Uterine Cancer _____	Thyroid Disorder _____
Cervical Cancer _____	Other Cancers/Diseases_____
Ovarian Cancer _____	_____
Colon Cancer _____	_____

Review of systems (mark if you **currently** have symptoms or have had **frequently**)

☐ Change in weight	☐ Blood in stool	☐ Fever/chills
☐ Fatigue/tiredness	☐ Blood in urine	☐ Change in vision
☐ Difficulty hearing	☐ Burning with urination	☐ Wear glasses/contacts
☐ Nasal drainage	☐ Incontinence of urine	☐ Vaginal discharge
☐ Congestion	☐ Frequency/urgency	☐ Menstrual cramps
☐ Sore throat	☐ Muscle/joint pain	☐ Pain with sex
☐ Wheezing	☐ Muscle weakness	☐ Bleeding after sex
☐ Cough	☐ Rash/change in mole	☐ Abnormal bleeding
☐ Headache	☐ Numbness/tingling	☐ Breast mass/discharge
☐ Dizziness/fainting	☐ Depression/anxiety	☐ Chest pains/palpitations
☐ Swollen legs	☐ Constipation	☐ Shortness of breath
☐ Varicose veins	☐ Diarrhea	☐ Abuse (current or history of)
☐ Easy bruising	☐ Nausea/vomiting	☐ Jaundice/liver disease

REVIEWED BY _____ M.D.