



Obstetrical and Gynecological Associates, P.A.

Date _____ Name _____ Age _____

Reason for today's visit? Preventative or Problem Visit (please circle one)

Gynecologic History:

Pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____ Living children _____
Last menstrual period _____ Are periods regular? _____ Any problems with periods? _____

At what age did your periods begin? _____

Are you trying to get pregnant? _____

Present type of contraception _____ Do you want to change? _____ To What? _____

Date of last Pap smear _____ Results _____

Y/N Have you ever had an abnormal pap or HPV test? Treatment? _____

Date of last Mammogram _____ Results _____

Y/N Have you ever had an abnormal mammogram or exam? Treatment? _____

Y/N Have you had a bone densitometry? When? _____ Results? _____

Y/N Have you had a colonoscopy? When? _____ Results? _____

Y/N Are you sexually active? Any difficulties or discomfort? _____

Age at 1st intercourse _____ Total number of sexual partners _____

Sexual preference: M / F / Both _____ Number of current sexual partners _____

Y/N Do you perform breast self exams? Any changes or concerns? _____

Y/N Any vaginal discharge atypical for you? Itching? _____ Odor? _____

Y/N Any bladder leakage? Explain _____

Y/N Have you ever had any sexually transmitted infections? What? _____

(ex. Herpes, Gonorrhea, Chlamydia, Trichomonas, HIV, Hepatitis B or C, Syphilis, HPV)

Y/N Are you involved in an abusive relationship? _____

Obstetrical History:

List pregnancies in chronological order:

Year	Sex	Baby's Weight	Hours in labor	Anesthesia	Vaginal or C-section	Complications	Child's name
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Medications:

Drug allergies _____

Medications list (include herbal and over-the-counter meds; include dosages for all)

Surgical History: (include approximate date)

Social History:

Occupation: _____ Marital status: single/ married _____ # years/ divorced/ widowed

Y/N Do you smoke? How much? _____

Y/N Do you drink alcohol? How much? _____

Y/N Do you use recreational drugs? Type & How much? _____

Y/N Do you exercise? How much? _____

Medical History:

Have **YOU** been treated for any of the following medical conditions? (please circle)

Seizures / epilepsy	Hepatitis – Type _____	Skin problems
Stroke	Colon Problems	Lupus
Migraines	Intestinal disease	Cancer – Type _____
Thyroid disease	Gallbladder disease	Blood clots
Heart problems	Kidney disease	Glaucoma
Heart attack	Kidney stones	High blood pressure
Asthma or pneumonia	Recurrent urinary infections	High cholesterol
Tuberculosis	Arthritis	Diabetes
Ulcers or reflux	Neurologic disease	Psychiatric problem

Please explain item above, or list other medical problems not listed: _____

Family History:

Is there a member of your immediate family with any of the following medical conditions?

Y/N Diabetes? Who? _____ Appx. age of onset _____

Y/N Heart disease? Who? _____ Appx. age of onset _____

Y/N High Blood Pressure? Who? _____ Appx. age of onset _____

Y/N High Cholesterol? Who? _____ Appx. age of onset _____

Y/N Osteoporosis? Who? _____ Appx. age of onset _____

Y/N Are you of Ashkenazi Jewish descent?

Please indicate any cancer diagnoses in your family:

Cancer Type	Yes	Relationship to you	Age at diagnosis	Living Y/N
Breast cancer				
Male breast cancer				
Multiple breast cancers in 1 individual				
Ovarian cancer				
Colon cancer				
Multiple colon cancers in 1 individual				
10 or more colon polyps in 1 individual				
Uterine (endometrial) cancer				
Stomach cancer				
Kidney / urinary tract cancer				
Brain cancer				
Small bowel cancer				
Billiary cancer				
Melanoma				
Pancreatic cancer				

List other significant medical problems or cancers in family members:

Please provide name and number of all other treating physicians and their specialty:

Do you allow us to discuss your results with them? Yes / No (circle one)

Signature _____