Austin ObGyn Associates

Patient Health History

Patient Name:_____ Date:_____

Prefer to be called:_____ DOB/Age:_____/_____

Occupation:_____ Referred By:_____

Reason for Visit:_____

Gyn History:

1st day of last menstrual cycle:_____ Age at first menstruation:_____ Cycle typically occurs every _____ days

Current method of birth control:_____

If taking oral contraceptive pills, how many pills have you forgotten to take in the last 3 months? _____

Are you sexually active?_____ Marital Status:_____ Date of last pap smear:_____

Do you have any history of the following?

Gyn

- ☐ Abnormal discharge
- ☐ Heavy cycles
- ☐ Painful cycles
- ☐ Irregular cycles
- ☐ Endometriosis
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ Fibroids/Polyps
- ☐ PCOS
- ☐ Infertility
- ☐ Urinary incontinence
- ☐ Abnormal pap smears
- ☐ Sexual assault
- ☐ Domestic violence

STDs

- ☐ Syphilis
- ☐ Herpes/HSV (II)
- ☐ HPV
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Genital warts
- ☐ Trichomoniasis

General

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Recurrent bladder infections

General continued

- ☐ Thyroid problems
- ☐ Hepatitis
- ☐ Asthma
- ☐ Nasal allergies
- ☐ Tuberculosis
- ☐ Bleeding disorder
- ☐ Blood clots in legs or pelvis
- ☐ Blood clot in lungs
- ☐ Arthritis
- ☐ Ulcer disease
- ☐ Gallbladder disease
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Seizure disorder
- ☐ Migraine headaches

Is there anything else that you would like to discuss with the doctor today?_____

_____

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OB History

Please list pregnancies in order of date. If miscarriage or abortion please write "AB" under type of delivery.

Pregnancy #/Year Type of Delivery (Vaginal, C-section, VBAC) Birth Weight Complications?

_____

_____

_____

_____

_____

Personal History

Any previous surgery? (if yes, please describe)_____

Any hospitalizations? (if yes, please describe)_____

Do you smoke? _____ If yes, how many packs per day? _____

Do you consume alcohol? _____ If yes, how many drinks per week or socially?_____

Do you consume recreational or illicit drugs?_____ If yes, which one(s)?_____

Do you exercise?_____ If yes, how often?_____ Type of exercise:_____

Do you have a primary care physician?_____ If yes, please list name:_____

Please list all medications (prescription or OTC) you are currently taking:_____

_____

Supplements/Herbs (please list)_____

_____

Please list all drug or material (ex: Latex) allergies and what reaction occurs:_____

_____

Family History

Mother: Alive☐ Age:_____ Current Medical Problems:_____

Deceased☐ Age at death:_____ Cause of death:_____

Father: Alive☐ Age:_____ Current Medical Problems:_____

Deceased☐ Age at death:_____ Cause of death:_____

Siblings: Alive☐ Age:_____ Current Medical Problems:_____

Deceased☐ Age at death:_____ Cause of death:_____

List any family history of birth defects:_____