Seattle Obstetrics & Gynecology Group OB/GYN

PROLIANCE SURGEONS

Patient Health History

Today's Date: _____ **Name:** _____ **Date of Birth:** _____ **Age:** _____

Reason for Visit/Concerns: _____

Primary Care Provider: _____ **Referred by**: _____

Marital Status: ☐Single ☐Dating ☐Married ☐Widowed ☐Divorced **Partner's name:** _____
Occupation: _____ **Ethnicity:** _____ **Pharmacy Name & Location:**_____
Allergies to Medication/Reaction_____

List Current Medications/Dose/Frequency (including birth control, over –the-counter medications and supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Menstrual History:

How old were you when you first started your period? _____ How many days between periods? _____

How many days do you bleed? _____ Flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Heavy with clots

First day of last period: _____ **Birth control method**: _____ Are you satisfied with this method?: _____

Do you have irregular periods? ☐ Yes ☐ No List any problems with your periods: _____

Are you attempting pregnancy? ☐ Yes ☐ No How long have you been attempting? _____

If you are postmenopausal: What age did your periods stop? ____ Have you had any postmenopausal bleeding? ☐ Yes ☐ No

Pregnancy History: List all pregnancies, including miscarriages and/or abortions

Pregnancies ___ Full-Term___ Pre-Term___ Abortions___ Miscarriages___ Tubal Pregnancies___ Multiple___ Living___

Date of Birth	Child's Name	Gender	Birth weight	Delivery Type	# Weeks At Delivery	Labor Hours	Birthplace	Complications

Sexual history:

Are you sexually active? ☐ Yes ☐ No Sexual preference: ☐Men ☐ Women ☐Both

Any new sexual partners in the last year? ☐ Yes ☐ No How long have you been with your current partner? _____

Do you want to be tested for STDs? ☐ Yes ☐ No HPV Vaccine Date: _____ Did you receive all 3 shots? ☐ Yes ☐ No

Date of last Pap Smear?: _____ Results:_____ History of abnormal Pap smears? Date(s): _____ Treatment: _____

Have you had a Mammogram? Date: _____ Results: _____ Have you had a cholesterol check? Date: _____ Results: _____

Have you had a colonoscopy? Date: _____ Results: _____ Have you had a Bone Density Scan? Date: _____ Results: _____

Gynecologic History: Please CHECK if YOU have or have ever had:

- ☐ Colposcopy
- ☐ Cervical Dysplasia
- ☐ Laser/Cryosurgery/Freezing/ Cone Biopsy/LEEP
- ☐ Genital Herpes (HSV II)
- ☐ Genital Warts (Condyloma)
- ☐ Cold Sores (HSV I)
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Trichomonas
- ☐ Syphilis
- ☐ HIV/AIDS
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Cervical Cancer
- ☐ Endometriosis
- ☐ Uterine Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Infertility
- ☐ Sexual Problems
- ☐ Painful Intercourse
- ☐ Lack of Sexual Desire
- ☐ Uterine Fibroids
- ☐ Fibrocystic Breast
- ☐ Ovarian Cyst
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Other: _____

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Personal Medical History: Please CHECK if YOU have or have ever had:

- ☐ Acne
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bacterial Vaginosis
- ☐ Blood clot in the leg or lung (DVT or PE)
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Excessive Hair Growth
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Recurrent Urinary Infections
- ☐ Recurrent yeast infections
- ☐ Seizure
- ☐ Skin Disease
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins

List any other **significant medical history**; please provide date and relevant comments: _____
_____

Surgical History: Please list surgery and date: _____
_____

Family Medical History: ☐ Check if you were adopted and do not know your family history

Please state which relatives (Maternal or Paternal) have had the following and their age at diagnosis:

- ☐ Breast Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Uterine Cancer_____
- ☐ Colon Cancer_____
- ☐ Other Cancer_____
- ☐ Heart Attack_____
- ☐ High Blood Pressure_____
- ☐ Deep Vein Thrombosis_____
- ☐ Stroke _____
- ☐ Heart Disease_____
- ☐ Diabetes _____
- ☐ Thyroid Disease _____
- ☐ Osteoporosis _____
- ☐ Birth Defects_____
- ☐ Other_____

Health Habits:

Tobacco use? ☐ Yes ☐ No ☐ Never Amount per day: _____ How long: _____ Plan to quit? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No ☐ Never Drinks per week: _____ Quit date: _____

Drug use? ☐ Yes ☐ No ☐ Never Type: _____ Quit date: _____

Caffeine per day: _____

Do you perform **self breast exams**? ☐ Yes ☐ No If so, how frequently? ☐ Monthly ☐ Occasionally ☐ Rarely ☐ Never

Do you **exercise**?: ☐ Heavy (4+ days/wk) ☐ Moderate (2+ days/wk) ☐ Minimal (once/wk) ☐ None

Do you use a seat belt? ☐ Yes ☐ No

Do you have any history of sexual abuse? ☐ Yes ☐ No

Do you feel safe at home/work? ☐ Yes ☐ No