OBSTETRICS & GYNECOLOGY
HEALTH ASSESSMENT

Name ________________________________ Date ____________

Address ________________________________

Phone (Home) ____________ (Work) ____________ Birth Date ____________

Occupation ____________ Marital Status ____________

DRUG ALLERGIES

CURRENT MEDICATION

FAMILY HISTORY

	Yes	No	Relationship
Heart Disease			
Hypertension			
Stroke			
Cancer			
Glaucoma			
Diabetes			
Epilepsy			
Bleeding disorder			
Kidney disease			
Thyroid disease			
Mental illness			
Alcoholism			
High Cholesterol			

PAST MEDICAL HISTORY

Please indicate any PAST medical problems

- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Stomach Problems
- ❑ Urinary Problems
- ❑ Muscles/ Bones
- ❑ Thyroid Disease
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Diabetes
- ❑ Venereal Disease
- ❑ Mental Illness
- ❑ Depression
- ❑ Epilepsy
- ❑ Breast Cancer
- ❑ DES Exposure
- ❑ Pelvic Inflammatory Disease
- ❑ Tumor of Any Kind

HOSPITALIZATION OR SURGERY

	Date		Date

HABITS

❑ Smoke: Yes No Packs Daily How long When stopped

❑ Exercise routine

❑ Alcohol: Type/Amount ❑ Drug or Alcohol Abuse

What is the main reason you are here today?

FOR PHYSICIAN USE ONLY

HEALTH ASSESSMENT

Menstrual Cycle

Do you have periods? .... Yes ☐ No ☐

If so, how often? ____________________

How long do they last? ____________________

Date of last period ____________________

Age when started first period ____________________

In general do you think that your periods are irregular? .... Yes ☐ No ☐

Do you skip periods? .... Yes ☐ No ☐

Do you have painful periods? .... Yes ☐ No ☐

Describe ____________________

Any recent changes in pain? .... Yes ☐ No ☐

Describe ____________________

Do you bleed between periods? .... Yes ☐ No ☐

Do you ever have pain ______ or bleed ______ during or after sexual activity? .... Yes ☐ No ☐

Describe ____________________

Pregnancy

Have you ever been pregnant? .... Yes ☐ No ☐

How many births have you had? ____________________

Date of most recent birth ____________________

How many abortions and how many miscarriages have you had? ____________________

Have you had any premature births or stillbirths or infant deaths? ____________________

Have you had any complications of pregnancy? Include heavy bleeding, infection, Caesarean section, toxemia or high blood pressure. Describe. ____________________

Pap Smear Results

Was your last Pap smear normal? .... Yes ☐ No ☐

Date of last Pap smear ____________________

Have you ever had an abnormal Pap smear?

Date ____________ Results ____________

Action taken: Include repeat Pap smear, colposcopy biopsy, cauterization, etc., date and results ____________________

Breasts

Do you practice self breast exams? .... Yes ☐ No ☐

Give date of last mammogram ____________________

Results ____________________

Hormone-like Drug Use

Did your mother, while pregnant with you, take diethystilbesterol (DES)? Yes ☐ No ☐ Don't Know ☐

Did your mother take any anti-miscarriage or other drugs while pregnant with you? Yes ☐ No ☐ Don't Know ☐

List drugs ____________________

Birth Control

List any birth control method you have used or are using:

Method	Dates Used	Problems/Benefits

Have you ever had any of the following conditions?

Gynecological Health Condition

Infection of uterus, tubes or ovaries (PID) ____________ Yes ☐ No ☐

Chlamydia ____________ Yes ☐ No ☐

Gonorrhea ____________ Yes ☐ No ☐

Syphilis ____________ Yes ☐ No ☐

Vaginal yeast ____________ Yes ☐ No ☐

Vaginal trichomonas ____________ Yes ☐ No ☐

Vaginal bacteria infection or non-specific infection ____________ Yes ☐ No ☐

Excessive uterine bleeding ____________ Yes ☐ No ☐

Breast lumps or cysts ____________ Yes ☐ No ☐

Breast discharge ____________ Yes ☐ No ☐

Herpes ____________ Yes ☐ No ☐

Genital sores ____________ Yes ☐ No ☐

Venereal warts ____________ Yes ☐ No ☐

Bladder infection ____________ Yes ☐ No ☐

Kidney problems ____________ Yes ☐ No ☐

Rectal bleeding ____________ Yes ☐ No ☐

Leakage of urine ____________ Yes ☐ No ☐