Carson Medical Group

OB/GYN Health History

Patient Name _____ Date of Birth _____

Gender Identification/Preferred Pronoun _____

SOCIAL HISTORY

Marital Status □ Single □ Married □ Long term relationship □ Divorced □ Widowed

Reason for visit _____

Primary Care Provider _____

Occupation _____

MENSTRUAL HISTORY

Age at first menstrual period _____ Age of menopause _____ First day of last menstrual period _____

If your menstrual periods are regular; periods start every: _____ days

If your menstrual periods are irregular; periods start every: _____ to _____ days (e.g., 12 to 60)

Duration of bleeding: _____ days Flow is: □ Heavy □ Regular □ Light

Is pain associated with periods? □ Yes (if yes is it □ before menses □ during menses or □ both) □ No □ Occasionally

PREGNANCY HISTORY (All pregnancies)

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES □ **Have never been pregnant**

Year	Location	Duration of Pregnancy	Type of delivery (c/s or vaginal)	Complications Mother and/or Infant	Sex (male or female)	Birth Weight

BIRTH CONTROL HISTORY

What birth control method(s) do you currently use (includes vasectomy)? _____

SEXUAL/GYN HISTORY

Do you have a sexual partner? □ Yes □ No (□ Male □ Female □ Both)

Check any that apply: □ Herpes – genital □ HPV □ Syphilis □ Pelvic inflammatory disease □ Vaginal infections

□ Endometriosis □ Chlamydia □ Gonorrhea □ Sexual abuse □ other _____ □ None

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PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

Check any that apply: or ☐ none

SURGERY	YEAR	SURGERY	YEAR
☐ D&C	_____	☐ Myomectomy (fibroid removal)	_____
☐ Hysteroscopy	_____	☐ Ovarian surgery	_____
☐ Infertility surgery	_____	☐ L ovary removed	_____
☐ Tubal ligation	_____	☐ R ovary removed	_____
☐ Laparoscopy	_____	☐ Vaginal or bladder repair for prolapse	
☐ Hysterectomy (vaginal)	_____	or incontinence	_____
☐ Hysterectomy (abdominal)	_____	☐ Cesarean section	_____
		☐ Other: _____	_____

PAST SURGICAL HISTORY (NOT OB/GYN)

List all surgeries and year: or ☐ none

	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

PAP SMEAR/MAMMOGRAM HISTORY

Date of last pap smear: _____ Have you had abnormal pap smears? ☐ Yes ☐ No

Have you had treatment for abnormal pap smears? ☐ Yes ☐ No

If yes what type? ☐ cryotherapy ☐ cone biopsy ☐ loop excision (LEEP) What year? _____

Date of last mammogram: (month/year) _____ Have you had an abnormal mammogram? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Check any that apply or ☐ none

☐ Diabetes	☐ Liver disease (including hepatitis)	☐ HIV+
☐ High blood pressure	☐ Epilepsy or seizure disorder	☐ Eating disorder
☐ Heart disease	☐ Blood clots	☐ Anxiety or depression
☐ Kidney disease	☐ Thyroid disease	☐ Migraines
☐ Gallstones	☐ Asthma	☐ Cancer type: _____

MEDICATION ALLERGIES

Do you have allergies to medication? ☐ Yes ☐ No If yes please list medications and reaction:

_____

_____

CURRENT MEDICATIONS (Include dose/amount per day)

Medication	Dose/amount	Frequency

DO YOU CURRENTLY?

Smoke or vape ☐ Yes packs/day _____ ☐ No Use marijuana ☐ Yes ☐ No

Use alcohol ☐ Yes ☐ No If yes how much and how often? _____

Use illicit drugs ☐ Yes ☐ No If yes what type and how often? _____

PREVENTATIVE CARE When was your last:

Colonoscopy _____ Flu vaccine _____ Gardasil vaccine _____

DEXA (bone density) scan _____ Tdap vaccine _____ Shingles vaccine _____

Labs _____ Pneumonia vaccine _____ COVID vaccine _____

FAMILY HISTORY Do you have family history of the following? If yes please indicate which family member.

	FAMILY MEMBER		**FAMILY MEMBER**
☐ Blood clots	_____	☐ Uterine cancer	_____
☐ Diabetes	_____	☐ Breast cancer	_____
☐ Heart disease	_____	☐ Colon cancer	_____
☐ Ovarian cancer	_____		

Other family history: _____

STOP here if you are not pregnant. If you are currently pregnant or planning pregnancy in the near future, continue.

GENETIC HISTORY

Have you and/or the father ever had genetic carrier screening? ☐ Yes ☐ No

Are you or the father Italian, Greek, Mediterranean, Asian, African American, or Ashkenazi Jewish? ☐ Yes ☐ No

Are you and the father blood related? ☐ Yes ☐ No

Do you or the father have family history of any genetic or chromosome disorders? ☐ Yes ☐ No

If yes what disorders and what relation to you? _____