

Westside Obstetrics and Gynecology Patient Comprehensive History Form

Date of appointment: _____

Referring physician: _____

Name: _____ Birth date: _____

Note: This record is confidential. Information will not be released to anyone without your authorization.

Why are you here today? Annual/pap Gyn health issue Pregnancy

If a Gyn health issue, please describe: _____

Is it associated with your menstrual periods? Yes No Does it effect your daily activities? Yes No

What makes it worse? _____ What makes it better? _____

Are you in pain? Yes No Rate your pain (Please Circle) [No pain] 0 1 2 3 4 5 6 7 8 9 10 [Worst Pain]

What has been done for this problem? _____

Gynecological History

Age of onset of menses: _____

When was your last pap smear? _____

When was your last mammogram? _____

Have you had a hysterectomy? Yes No

Do you still have your ovaries? Yes No

If menopausal, age of last menses _____

First day of last menstrual period: _____

How often do you get your period?

- Less Than 20 Days Apart 21-35 Days Apart
 More Than 36 Days Apart

How many days does your period last? (Check one)

- Less Than 2 Days 2-5 Days 5-7 Days
 7-10 Days More Than 10 Days

How many pads/tampons do you use on heavy days? _____

Which form of birth control (if any) do you use?

Pill/Patch/Ring Depo-Provera IUD Condom Vasectomy Tubal Ligation/Essure Other _____

Have you had the HPV vaccine (Gardasil) Yes No

Do you pass clots? Yes No
Do you miss school/work monthly? Yes No
Do you spot/bleed between periods? Yes No
Do you have bleeding after intercourse? Yes No
Do you have pain with your periods? Yes No
Do you have pain with intercourse? Yes No
Do you have abnormal vaginal discharge? Yes No
Is there odor? Yes No Color? _____
Have you had an abnormal pap smear? Yes No
Have you had surgery to your cervix? Yes No
Describe _____
Hx of infertility treatment? Yes No
Have you had Herpes? Yes No
Have you had Genital Warts? Yes No
Have you had Chlamydia or Gonorrhea? Yes No
Are you a Jehovah's Witness? Yes No

Notes

Medical History - Patient

Have you had or do you presently have any of the following?

Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lupus/autoimmune dz	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease or Trait	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma/accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease (asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis/osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic disorder/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phlebitis or Blood Clots (in your legs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please describe any "Yes" answers: _____

Family History

Please list the members of your family (parents, brothers, sisters, grandparents, children) with their ages, and significant illnesses

Relationship	Mother	Father					
Age							
Deceased?	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:	<input type="checkbox"/> Yes, age:
Hypertension							
Heart Disease							
Diabetes							
Mental Illness							
Alcoholism							
Breast Cancer							
Leg blood clot (DVT)							
Ovarian cancer							
Colon cancer							
Other illnesses							

Notes _____

Medication (Prescription, Birth Control Pills, Over the Counter, Herbal, and Nutritional Supplementation)

Name	Dosage	Frequency	Name	Dosage	Frequency

Notes _____

Allergies (Please list any allergies to medications and food)

Latex allergy Yes No

Medication/Food	Reaction	Medication/Food	Reaction

Surgical History

Procedure		Complications	Surgeon/Hospital
Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Cervical Cone/LEEP	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Gallbladder	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Hysterectomy (Uterus)	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Laparoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Ovaries Removed	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
Tubal Ligation	<input type="checkbox"/> Yes <input type="checkbox"/> No, Date: _____		
All Other: (i.e. breast biopsy/colonoscopy)			

Obstetric History (Please fill in below)

of pregnancies ____, # of children ____, # of miscarriages ____, # of terminations ____, Tubal (ectopic) Yes No

Birth Date	Length of Pregnancy (weeks)	Length of Labor (Hours)	Delivery Route (Vaginal/ C-section)	Anesthesia (If Any)	Gender (M/F)	Infant Weight	Complications

Social History

Marital Status: Single Married Divorced Widowed Occupation: _____
 Are you sexually active? Yes No Number of partners in the past year? _____
 Alcohol use: Yes No If yes, describe: _____ Previously, but not now
 Tobacco use: Yes No Packs per day: _____ Previously, but not now
 Street Drug use: Yes No If yes, describe: _____ Previously, but not now
 Do you ever feel unsafe at home? Yes No Has anyone at home hit you or tried to injure you? Yes No
 Have you ever felt afraid of your partner? Yes No Has anyone ever threatened you or tried to control you? Yes No
 Do you exercise regularly? Yes No

Review of Systems

Have you experienced any of the following in the past 6 months? Please check "Yes" or "No"

Constitutional

- Good general health lately..... Yes No
- Recent weight change..... Yes No
- Fever..... Yes No
- Fatigue..... Yes No
- Headaches..... Yes No

Eyes, Ears, Nose and Throat

- Blurred or double vision..... Yes No
- Glaucoma..... Yes No
- Hearing loss..... Yes No
- Sinus problems..... Yes No
- Nose bleeds..... Yes No
- Sore throat or voice changes..... Yes No
- Swollen glands in neck..... Yes No

Cardiovascular

- Chest pain..... Yes No
- Leg swelling..... Yes No
- Palpitations..... Yes No
- Heart trouble..... Yes No

Respiratory

- Cough..... Yes No
- Shortness of breath..... Yes No
- Spitting up blood..... Yes No
- Asthma..... Yes No

Gastrointestinal

- Loss of appetite..... Yes No
- Nausea or vomiting..... Yes No
- Irritable bowel syndrome..... Yes No
- Blood in stool..... Yes No
- Change in bowel habits..... Yes No
- Chronic constipation/diarrhea..... Yes No

Genitourinary

- Burning or vaginal discomfort..... Yes No
- Vaginal dryness..... Yes No
- Vaginal itching..... Yes No
- Genital lesions or sores..... Yes No
- Decreased sexual desire..... Yes No
- Breast pain..... Yes No
- Breast lump..... Yes No
- Nipple discharge..... Yes No
- Is there blood in your urine?..... Yes No

Do you wet yourself with any of the following:

coughing, sneezing, laughing, running, lifting? Yes No

Do you have painful bowel movements? Yes No

Hematological

- Blood clotting disorder..... Yes No
- Easily bruise or bleeding..... Yes No
- Bleeding gums..... Yes No

Endocrine

- Excessive thirst or urination..... Yes No
- Problems with being too hot or cold. Yes No

Neurological

- Convulsions or seizures..... Yes No
- Tremors..... Yes No
- Frequent headaches..... Yes No

Psychiatric

- Depression..... Yes No
- Anxiety..... Yes No
- Sleep problems..... Yes No
- Memory loss or confusion..... Yes No
- Irritability..... Yes No

Are there any other problems you need to discuss with your physician? _____

Patient Signature _____

Date _____

Completed by (If other than patient) _____

Relationship to Patient _____

Physician Signature _____

Date reviewed ____/____/____

____/____/____

____/____/____

____/____/____