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**OBSTETRICS & GYNECOLOGY  
MEDICAL HISTORY FORM**

Age: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_  
FOR OFFICE USE

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*What is the main reason for today's visit?* (List below or check boxes on the right)

\_\_\_\_\_

\_\_\_\_\_

- PAP Smear
- Breast Exam
- Mammogram
- Birth Control Pills
- Hormone Medication
- Vaginal Infection

*Obstetrical History*       **NEVER PREGNANT**      (G \_\_\_\_\_ P \_\_\_\_\_)

How many times have you been pregnant? \_\_\_\_\_      How many miscarriages did you have? \_\_\_\_\_

How many children have you delivered? \_\_\_\_\_      How many abortions did you have? \_\_\_\_\_

    How many were born full term (37 weeks or greater)? \_\_\_\_\_      How many children are currently living? \_\_\_\_\_

    How many were premature (less than 37 weeks)? \_\_\_\_\_      How many sets of twins? \_\_\_\_\_

*Gynecologic & Menstrual History*

When was the First Day of your Last Menstrual Period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  NONE

What age did you have your First Menstrual Period? \_\_\_\_\_ years old

When was your last PAP Smear? (OK to give approximate date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  NEVER DONE

    My last PAP Smear was  normal or  abnormal or  I don't know

    Have you ever had any Abnormal PAP Smears?  Yes  No

When was your last Mammogram? (OK to give approximate date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  NEVER DONE

    My last Mammogram was  normal or  abnormal or  I don't know

Check the following Infections or Sexually Transmitted Disease (STD or Venereal Disease) you have had in the past.

NEVER DONE       Hepatitis ( B or  C)       Bacterial Vaginosis (Gardnerella)       Others: \_\_\_\_\_

Chlamydia       Syphilis       Human Papilloma Virus (HPV)

Gonorrhea (GC, Clap)       Trichomoniasis       Herpes ( Genital or  Oral)

How many Sexual Partners in your lifetime?  0  1 - 4  5 or greater      Currently Sexually Active?  Yes  No  
(Optional question)

What form of Birth Control are you using?

NONE       Condoms       Depo-Provera Shots (Date last shot given: \_\_\_\_/\_\_\_\_/\_\_\_\_)

Rhythm Method / Natural Family Planning       Withdrawal       Contraceptive Film

I had a Tubal Sterilization (Tubes Tied)       Spermicide       Birth Control Pills (Brand: \_\_\_\_\_)

I had a Hysterectomy (Uterus removed)       Norplant       Birth Control Patch

My partner had a Vasectomy       Diaphragm       Birth Control Ring

IUD       Other: \_\_\_\_\_

Have you gone through Menopause?  No  Yes (What age? \_\_\_\_\_)      Hormone Medicine: \_\_\_\_\_

*Medical History*      (Check your following Medical Problems)       **NO MEDICAL PROBLEMS EVER DIAGNOSED**

<input type="checkbox"/> Breast Cancer (Mo/Yr _____)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Loss of Urine Control	<input type="checkbox"/> Osteoporosis or <input type="checkbox"/> Osteopenia
<input type="checkbox"/> Ovarian Cancer (Mo/Yr _____)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Colon Cancer (Mo/Yr _____)	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Frequent Bladder Infection	<input type="checkbox"/> Depression
<input type="checkbox"/> Uterus Cancer (Mo/Yr _____)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Vaginal Dryness / Itching	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Cervix Cancer (Mo/Yr _____)	<input type="checkbox"/> Irregular Heart Rate	<input type="checkbox"/> Frequent Vaginal Infection	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> Other Cancer: _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Painful Intercourse	Are You Safe Now? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pelvic Inflammatory Disease / PID	<input type="checkbox"/> Domestic Abuse
<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Low Thyroid	<input type="checkbox"/> Abnormal Heavy Vaginal Bleeding	Are You Safe Now? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High Thyroid	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Psychiatric Problems
Where? _____	<input type="checkbox"/> Migraines	<input type="checkbox"/> Fibrocystic Breasts	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Nipple Discharge	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cervical Dysplasia	<input type="checkbox"/> Others: _____

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

FOR OFFICE USE

**Surgical History** (Check your following Surgeries or Procedures)  NEVER HAD ANY SURGERY

- Tubal Ligation
- Cesarean Section
- Hysterectomy (Year \_\_\_\_\_)  
(Reason: \_\_\_\_\_)  
( Abdominal or  Vaginal)
- Myomectomy, Fibroid Removal
- Ovaries removed  
( Both  Lt  Rt)
- Ovary cyst removal surgery  
( Both  Lt  Rt)
- Ectopic Pregnancy surgery  
( Abdominal  Laparoscopic)  
( Both  Lt  Rt)
- Bladder surgery
- Cervix surgery: \_\_\_\_\_  
 Cryotherapy (Freezing)  
 LEEP (Heated Wire)  
 Conization (Cold Knife Cutting)
- Laparoscopy
- D&C (Dilatation & Curettage)
- Hysteroscopy
- Endometrial Ablation
- Vaginal surgery
- Breast lump removal  
( Both  Lt  Rt)  
( Benign or  Malignant)
- Mastectomy  
( Both  Lt  Rt)
- Breast implants or  Reduction
- Tonsillectomy
- Thyroid surgery
- Heart surgery
- Stomach surgery
- Lung surgery
- Liver surgery
- Gallbladder surgery
- Appendectomy (Appendix)
- Splenectomy (Spleen)
- Umbilical Hernia Repair
- Abdominoplasty (Tummy Tuck)
- Colon surgery
- Colonoscopy (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_)
- Sigmoidoscopy (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_)
- Hemorrhoid surgery
- Lower GI - Barium Enema
- Bone Fracture surgery (Which bones? \_\_\_\_\_)
- Spinal surgery (Level: \_\_\_\_\_)
- DEXA Bone Density Scan (Date: \_\_\_\_/\_\_\_\_/\_\_\_\_)
- Others: \_\_\_\_\_

**Family History** (Check the following Cancers or List Medical Conditions found in Family Member)

	Yes	None	Age	Relation (Grandparents, Father/Mother, Brother/Sister, Children, Etc.)
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other Medical Problems in the Family:	_____			

**Social History** (Check appropriate boxes)

- Marital Status:  Single  Married  Living with Partner  Widowed  Divorced / Separated
- Occupation: \_\_\_\_\_  Homemaker  Student  Retired
- Do you smoke tobacco / cigarettes?  No  Yes: \_\_\_\_ ( packs or  cigarettes) per ( day or  week)  Quit (Date: \_\_\_\_\_)
- Do you drink alcohol?  No  Yes: \_\_\_\_ drinks per ( day or  week)  Social, Rarely  Quit (Date: \_\_\_\_\_)
- Which illicit drugs have you used?  NONE  Marijuana  Methamphetamine  Others: \_\_\_\_\_  
(Optional question)  Cocaine, Crack  PCP, LSD  
 Ecstasy, MDMA  Morphine, Heroin  Quit using all illicit drugs

**What MEDICATIONS are you currently taking?**  NOT TAKING ANY MEDICATIONS

Medication Name	Dosage (mg, gram, IU, etc.) & Frequency (once or twice a day, etc.)	Medication Name	Dosage (mg, gram, IU, etc.) & Frequency (once or twice a day, etc.)
_____	_____	_____	_____
_____	_____	_____	_____

**List MEDICATIONS you are ALLERGIC to and your REACTIONS.**  NO KNOWN DRUG ALLERGIES

Allergic Medication Name: \_\_\_\_\_ Type of Reaction (rash, hives, throat swelling, shortness of breath, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LATEX ALLERGY

**THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORDS**

Patient Signature: \_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_