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for women
OB/GYN
associates

# Female Medical History

## Do you have any of the following problems?

| Generalized Symptoms | Yes / No |
|---|---|
| Anxiety: | ❒ ❒ |
| Depression: | ❒ ❒ |
| Diabetes: | ❒ ❒ |
| Fatigue: | ❒ ❒ |
| High Cholesterol: | ❒ ❒ |
| Nervousness: | ❒ ❒ |
| Seizures: | ❒ ❒ |
| Sleep Disorders: | ❒ ❒ |
| Stress: | ❒ ❒ |
| Substance Abuse: | ❒ ❒ |
| Thyroid - Overactive: | ❒ ❒ |
| Thyroid - Underactive: | ❒ ❒ |

| Urinary | Yes / No |
|---|---|
| Painful Urination: | ❒ ❒ |
| Urinary Incontinence: | ❒ ❒ |
| Urinary Urgency: | ❒ ❒ |

| Musculoskeletal | Yes / No |
|---|---|
| Back Pain: | ❒ ❒ |
| Joint Pain: | ❒ ❒ |
| Muscle Cramps: | ❒ ❒ |

| Gynecological | Yes / No |
|---|---|
| Cervical Disease: | ❒ ❒ |
| Genital Sores: | ❒ ❒ |
| Heavy Bleeding: | ❒ ❒ |
| Vaginal Discharge: | ❒ ❒ |

## Do you have any of the following symptoms?

| | Yes / No |
|---|---|
| Bloating: | ❒ ❒ |
| Breast Tenderness: | ❒ ❒ |
| Cramping: | ❒ ❒ |

Vaginal Itching: ❒ ❒
Vaginal Odor: ❒ ❒
Contraception Method:

Moodiness: ❒ ❒

## Menstrual History:

Date of Your Last Menstrual Period: _____

Age You Had Your First Period: _____

Menstruation every _____ days.

Length of Menstruation _____ days.

**Menstrual Bleeding**

Light ❒

Moderate ❒

Heavy ❒

## Last Pap Test:

Date: _____

**Results**

Normal: ❒

Abnormal: ❒

Unknown: ❒

**Preventive Screening Dates**

Last Mammography: _____

Bone Density Screening: _____

Colonoscopy: _____

## Obstetric History:

Total Number of Pregnancies: _____

Abortions - Elective: _____

Full Term Births: _____

Miscarriages: _____

Premature Births: _____

Multiple Births: _____

Ectopic: _____

Total Number of Children: _____

**Sexual Activity**

Never: ❒

Current: ❒

**Partners**

Spouse: ❒

Significant Other: ❒

Male: ❒

Female: ❒

Number of Lifetime Partners: _____

Are there concerns about your sexual activity which you may want to discuss with your doctor? **Yes / No** ❒

## Menopause History

Age at Menopause: _____

| | Yes / No | | Yes / No |
|---|---|---|---|
| Taking Hormone Therapy: | ❒ ❒ | Night Sweats | ❒ ❒ |
| Hot Flashes: | ❒ ❒ | Painful Intercourse: | ❒ ❒ |
| Insomnia: | ❒ ❒ | Skipping Periods: | ❒ ❒ |
| Irregular Bleeding: | ❒ ❒ | Vaginal Dryness: | ❒ ❒ |

## Past Obstetrical/gynecological surgeries:

- 
- 
- 
- 
- 

## List Any Additional Medical Problems:

- 
- 
- 
- 
- 

## List Current Medications:

- 
- 
- 
- 
- 

## Pharmacy name - Preferred:

Prefer 30 Day Refill: ❒

Prefer 90 Day Refill: ❒

## List Any Known Allergies:

## Social History

Marital Status: _____

Smoker - Cigarettes per Day: _____

Alcohol - Drinks per Week: _____

History of Drug Use: _____

| | Yes / No |
|---|---|
| Are You Employed? | ❒ ❒ |

Occupation: _____