MIDWEST
OB/GYN & MIDWIFERY

WOMEN'S MEDICAL HISTORY

Name: _____
Referred by: _____
Age: _____ Occupation_____

REASON FOR SEEING DOCTOR TODAY

_____

OBSTETRIC HISTORY

Total Number of Pregnancies _____ Complications of Pregnancy:

History No. of Term Births _____ □ Diabetes
No. of Pre-Term Births_____ □High blood pressure
No. of Miscarriages _____ □ C-section
No. of Abortions _____ □ Toxemia
No. of Ectopic Pregnancies _____
No. of Living Children _____
□ Other:_____

Date of Birth	Birth Weight	Gender	Place of Bir

GYNECOLOGIC INFORMATION

Contraceptive History: check all birth control methods you have used
□ Natural Family Planning or Rhythm Method □ Spermicidal/Foam □ Condoms □ Diaphragm □ Norplant
□ Depo-Provera Injections □ IUD □ Tubal Ligation □ Vasectomy
□ Oral Contraceptives/Type _____
Any complications _____
Sexual History:
Are you currently sexually active? □ Yes □ No
If no, have you ever been? □ Yes □ No

Gynecologic History
Age of first menstruation ____ Interval between Periods _____ Days of Bleeding ____
Date of last normal menstrual period _____ usual number of pads/tampons on heaviest day ____
Do you have pain/cramps with your period? □ None □ Mild □ Moderate □ Severe
If menopause, year began? _____ Any bleeding since? □ Yes □ No
Last mammogram _____ Last bone density test _____ Colonoscopy _____
Have you ever had an abnormal Pap test? □ Yes □ No
Have you ever had a colposcopy or biopsy? □ Yes □ No
Do you bleed between your periods? □ Yes □ No
Do you experience pain with intercourse? □ Yes □ No
Do you experience bleeding after intercourse? □ Yes □ No
Do you experience pain between periods? □ Yes □ No
Are you currently experiencing vaginal discharge? □ Yes □ No
Are you currently experiencing vaginal itching or discomfort? □ Yes □ No
Have you experienced leakage from bladder or bowel? □ Yes □ No

Do you have or have ever had

Fibroids/myomas	□ Yes □ No	Gonorrhea	□ Yes □ No	Pelvic Inflammatory Disease	□ Yes □ No
Endometriosis	□ Yes □ No	Chlamydia	□ Yes □ No	Bacterial Vaginosis	□ Yes □ No
Infertility	□ Yes □ No	Syphilis	□ Yes □ No	Yeast	□ Yes □ No
		Genital warts/HPV	□ Yes □ No	Trichomonas	□ Yes □ No
		Herpes	□ Yes □ No		
		HIV/AIDS	□ Yes □ No		

MEDICATIONS and ALLERGIES

Are you on any medications (including contraception)?
1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Do you take any:
Herbal products □ Yes □ No
Vitamins □ Yes □ No
Minerals □ Yes □ No

Do you have any allergies to any medications □ Yes □ No
Penicillin? □ Yes □ No Reaction _____ Sulfa Drugs? □ Yes □ No Reaction _____
Codeine? □ Yes □ No Reaction _____ Other _____Reaction_____

 Name: _____

MEDICAL HISTORY (check all those that apply)

□ Ovarian Cancer □ High Blood Pressure □ Diabetes □ Asthma □ Lung Disease □ Sickle Cell
□ Uterine Cancer □ Thyroid Disease □ Lupus □ UTIs □ Kidney Disease □ Kidney stones
□ Cervical Cancer □ Hepatitis □ Gallbladder □ Blood Clots □ Irritable Bowel/Colitis □ Anemia
□ Breast Cancer □ Skin Cancer □ Blood disorder □ Depression □ Anxiety □ GI Reflux/Ulcers
□ Other _____

PAST SURGICAL HISTORY (check all those that apply)

□ Hysterectomy □ Gallbladder □ Thyroid □ Appendix □ Hernia □ Tonsils
□ Wisdom Teeth □ Spine/Joint □ Heart □ Other _____

VACCINATION HISTORY (check all those that apply)

□ Hepatitis B □ Pneumonia □ Chicken Pox (or history of) □ TDaP □ HPV/Gardasil □ Measles/Mumps/Rubella
□ Influenza

SOCIAL HISTORY

Do you smoke? □ Yes □ No
How much _____
Total years _____
Quit date _____
Have you ever used illicit drugs □ Yes □ No
Have you ever been sexually abused? □ Yes □ No

Do you drink alcohol □ Yes □ No
How much? □ 1-7 /week □ >8 /week
Has anyone been concerned? □ Yes □ No
Have you ever been physically abused? □ Yes □ No

FAMILY HISTORY

□ Heart Disease □ Thyroid □ Uterine Cancer □ Breast Cancer □ Osteoporosis □ High Blood Pressure □ Diabetes
□ Ovarian Cancer □ Colon Cancer □ Endometriosis □ Leukemia/lymphoma □ Skin cancer □ Other _____

Are your parents still living? _____ Are you Adopted? _____

REVIEW OF SYMPTOMS (check if you currently have any of the following symptoms)

General
Weight gain/loss □ Yes □ No
Loss of appetite □ Yes □ No
Fatigue/Weakness □ Yes □ No

Breast
Lumps □ Yes □ No
Discharge □ Yes □ No

Eyes
Wear contacts □ Yes □ No
Blurry vision □ Yes □ No

Ear/Nose/Throat
Trouble hearing □ Yes □ No
Nosebleeds □ Yes □ No
Mouth sores □ Yes □ No
Congestion □ Yes □ No

Skin
Changing Moles □ Yes □ No
Rash □ Yes □ No

Respiratory
Persistent Cough □ Yes □ No
Shortness of Breath □ Yes □ No

Heart
Palpitations □ Yes □ No
Blood Clots □ Yes □ No
Murmur □ Yes □ No

Gastrointestinal
Bloating □ Yes □ No
Constipation □ Yes □ No
Diarrhea □ Yes □ No
Blood in stool □ Yes □ No
Nausea/Vomit □ Yes □ No
Heartburn □ Yes □ No

Urinary
Leaking bladder □ Yes □ No
Blood in urine □ Yes □ No
>2 nightly □ Yes □ No
Frequent urination □ Yes □ No

Muscles
Joint pain □ Yes □ No
Chronic Back pain □ Yes □ No

Endocrine
Abnormal hair growth □ Yes □ No
Heat intolerance □ Yes □ No
Cold intolerance □ Yes □ No
Hot flashes □ Yes □ No
Night sweats □ Yes □ No

Mental Health
Marital problems □ Yes □ No
Persistent anxiety □ Yes □ No
Trouble sleeping □ Yes □ No
Depressed □ Yes □ No
Suicidal thoughts □ Yes □ No

Neuro
Chronic headaches □ Yes □ No
Seizures □ Yes □ No