Associated Valley Obstetrics & Gynecology

Today's Date________________________________

Legal Name____ Date of Birth___________________Age__________
First Middle Last

Phone Numbers: Work_____________________ Home_____________________ Cell_____________________
Social Security Number____________________ Email_____________________ Do you prefer chaperone during exam? Y/N
Reason for today's visit? ____

This information is confidential. It will only be released at your written request.
If you are a minor, we cannot discuss this or your care with your parents without your consent.

Medical History - Have you ever been diagnosed with any of the following? Please circle all that apply.

Alcohol abuse
Anxiety
Asthma
Bipolar disorder
Bleeding disorder
Bowel disease (IBS/IBD)
Breast cancer
Cancer (other)
Depression
Diabetes
Drug abuse
Epilepsy/seizures
GERD/Peptic ulcer
Glaucoma
Hearing problems
Heart disease
Hepatitis (A/B/C)
High blood pressure
High cholesterol
Infertility
Liver disease
Lung disease/tuberculosis
Mental health problems
Migraine headaches
Multiple sclerosis
Neurological problems
Osteoporosis/Osteopenia
Polycystic ovarian syndrome
Pelvic/hip injury
Recurrent UTI
Stroke
Thyroid disease (hypo/hyper)
Transfusions

Other____

Family Health History - Has anyone in your family including grandparents; parents or siblings ever had the following. Please circle all that apply. Please indicate relationship.

Birth defects
Blood clots in legs/lungs
Breast cancer
Cervical cancer
Colon cancer
Diabetes
Endometriosis
Heart disease
High blood pressure
High cholesterol
Osteoporosis
Ovarian cancer
Skin cancer
Stroke
Thyroid disease
Uterine cancer

Medications and Allergies

Any known drug allergies? Please list allergy and reaction ____
Please list all medications and why you are taking them.

Medication	Reason for medication	Medication	Reason for medication

Any vitamins or natural supplements? ____

Surgery and Hospitalizations - Give year or your age when done.

Appendectomy___________ Cesarean section_______ Gall bladder________________ LEEP/Cervical Cone_________
Blood transfusions_________ D&C___________ Hysterectomy_______________ Tonsillectomy_______________
Breast surgery _____________ Gyn Surgery ___________ Laparoscopy________________ Tubal ligation_______________
Other hospitalizations____

Gynecologic History / Immunization History - Please provide dates where appropriate

Last pelvic exam ____________ Last pap smear ___________
Prior abnormal pap smear ___Yes ____ No / Treatments for abnormal pap smear(s) ______________________________
Have you had the HPV vaccine series? (Gardasil 4 or 9?) ____Yes ___No
Date and place of last mammogram____
Have your had colon cancer screening (colonoscopy, stool blood test, sigmoidoscopy)? ____Yes ____No
Have you had Genital herpes, Chlamydia, gonorrhea or pelvic inflammatory disease? ____Yes ____No
Do you currently have vaginal itching, odor or abnormal discharge? ____Yes ____No
Have you had your cholesterol checked in the past 3 years? ____Yes ____No

Menstrual History (if menstruating)

Date of last period________________________________
Do you have painful cramps ____Yes ____No
Do you take medicine for cramps ____Yes ____No
Do you have PMS ____Yes ____No
Was the last period normal for you ____Yes ____No
Do you skip periods ____Yes ____No
How many days between periods _______________

How old were you with your first period____________________
Do you bleed between periods ____Yes ____No
Are your periods prolonged more than nine days ____Yes ____No
Is heavy flow a problem ____Yes ____No
Do periods/PMS keep you home ____Yes ____No
Any bleeding after or during sex ____Yes ____No
How many days do periods typically last _____

Menopause History (if menopausal)

Do you have hot flashes ____Yes ____No
Do you have vaginal dryness ____Yes ____No
Do you have urinary frequency ____Yes ____No
Have you had a bone density test ____Yes ____No

Have you ever used hormone replacement ____Yes ____No
Do you have problems with low sex drive ____Yes ____No
Do you have loss of urine (incontinence) ____Yes ____No

Pregnancy History

Date	Type (Vaginal, Cesarean)	Weight	Gender	Anesthesia (epidural, spinal)	Complications

Sexual History (Complete any that apply to you)

Age you started having intercourse_________________
Do you have a male partner ____Yes ___No
Do you have a female partner ___Yes ____No
Is your sexual activity satisfactory ___Yes ____No
Any pain with intercourse ___Yes ____No
Do you/partner have other partners? ___Yes ____No
How many partners have you had
Lifetime_____ Last Year_____
Do you wish to have STD testing today ___Yes ___No

Do you feel safe in your relationship ___Yes ___No
Are you or your partner using birth control ___Yes ___No
What type____
Are you satisfied with your birth control method ___Yes ___No
Has your partner had a vasectomy ___Yes ___No
Does your partner use a condom consistently ___Yes ___No
Do you need information of safe sex practices ___Yes ___No

Health Habits

Do you smoke? ____Yes ____No
Packs per day _____
Have you smoked in the past ____Yes ____No
Quit date__________________
Do you use street drugs? ____Yes ____No
What kind(s)____________________
Have you in the past ____Yes ____No
IV drug use ____Yes ____No

Do you drink alcohol? ___Yes ___No
_____Rarely ____Daily ____Weekly
Do you think you have a problem with alcohol ____Yes ____No
Do you wear seat belts when driving ____Yes ____No
Do you exercise regularly ____Yes ____No
How many times per week/what type?
____

Social History

Marital status (circle): Single Married Divorced Widowed Separated Living with
Current occupation_______________________________ Who referred you to our office_______________________________
Who is your primary care physician____
Other doctors you see ____