



Tuality Obstetrics & Gynecology

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Welcome to our clinic. In order to provide you with the best care possible, we need to ask you about various aspects of your health history. We ask these questions of all of our clients, so some of them may not apply to you. If you feel uncertain about a question, please feel free to leave it blank. Your clinician will go over this form with you as well. Thank you for your time.

Name _____ Age _____ DOB _____ Date _____

Primary Care Provider: _____ Who referred you to our clinic? _____

Do you have any special questions or concerns today? If so, please describe _____

OB-1030 (3/10)

MEDICAL HISTORY

Please check any of the following categories if you have ever had problems with:

- Nose / Sinus _____
- Headaches _____ Migraines _____
- Seizures _____
- Excessive Thirst _____
- Thyroid / Neck _____
- Breasts _____
- Heart problem _____ Chest pain _____
- High blood pressure _____
- History of abuse _____
(Physical / Emotional / Sexual) _____
- Mental health problems / Suicide attempts _____
- High Cholesterol _____
- Blood clots / Bleeding problems _____
- Stomach / Digestive problems _____
- Liver / Gall bladder _____
- Kidney / Urinary problems _____
- Joint / Muscle problems _____
- Anemia _____
- Genetic conditions _____
- Cancer _____
- Diabetes _____
- Breathing problems / Asthma _____
- TB / Postivie PPD _____
- Other _____

Any hospitalization (other than childbirth)? _____

Past Surgical History

List any surgeries and include dates: (Please include C-Sections and D&C's)

Obstetrical History

Number of Pregnancies _____ Number of Live Births _____ Number of Miscarriages / Abortions _____

Number of Premature Births _____ Number of Still Births _____ Number of Ectopic Pregnancies _____

Number of Living Children _____ Ages? _____

Any Diabetes or High blood pressure during pregnancy? Are you breastfeeding Yes No

Gynecologic History

Date of last Pap Smear: _____ Was it normal? Yes No

Ever had an abnormal Pap? Yes No Did it require any treatment? _____

Date of last mammogram: _____ Was it normal? Yes No

Ever had an abnormal mammogram? Yes No Did it require any treatment? _____

Are you sexually active? Yes No Are your sexual partners: Male Female Both

Age at first sexual intercourse: _____ Number of partners: _____

If you are menopausal, please skip this section and go to the next.

First day of your last menstrual period _____ Are your periods regular? Yes No

Age when periods started? _____

How long from the beginning of one to the beginning of the next? _____ How many days do they last? _____

Are they painful? Yes No Any PMS symptoms? Yes No Are you trying to get pregnant? Yes No

If not, what birth control method are you using? _____

For our menopausal patients:

How old were you when you had your last period? _____

Are you currently taking any Hormone Replacement Therapy? Yes No

If yes, list type and dose: _____

Any hot flashes, insomnia, vaginal dryness? Yes No Have you had a bone mineral density scan? Yes No

Are you having any of these symptoms now?

Vaginal itching Vaginal irritation Vaginal Sores Unusual discharge

Abnormal bleeding Pain with urination Pain with sexual activity Leaking Urine

Have you ever had:

Chlamydia _____ Infertility problems _____

Gonorrhea _____ Recurrent yeast infections _____

Syphilis _____ Cancer of the cervix, uterus, vagina or ovaries _____

Trichomoniasis _____ Uterine problems _____

Herpes _____ Endometriosis _____

Venereal warts / HPV _____ Ovarian Cysts _____

Pelvic Inflammatory Disease _____ Other _____

Medications

Do you currently take any medications? Yes No Please list (including over the counter, prescriptions, herbal / vitamins)

Medication allergies: _____ Reaction: _____
