GRAPEVINE OBGYN

PATIENT HISTORY FORM

Name: Date:

Last First

Date of Birth: Age:

Main Reason for your visit today:

MEDICAL HISTORY

Height: Weight: Drug Allergies:

Current Medications:

Hormone/Contraceptive Use:

SURGICAL HISTORY

Surgery and/or Hospitalization:	Year	Surgery and/or Hospitalization:	Year

Medical Problems: (check any that apply to you)

☐ Anemia	☐ Heart Disease	☐ Pelvic Pain
☐ Asthma	☐ High Blood Pressure	☐ Pain with Intercourse
☐ Blood Clots	☐ Infertility	☐ Psychiatric Illness
☐ Bleeding Disorders	☐ Irritable Bowel	☐ Seizure Disorder
☐ Breast Mass	☐ Kidney Stones	☐ Recurrent Bladder Infections
☐ Cancer of any type	☐ Liver Disease/Hepatitis	☐ Recurrent Vaginal Infections
☐ Depression	☐ Migraines	☐ Stomach Ulcers/Reflux Disease
☐ Diabetes	☐ Mitral Valve Prolapse/Murmur	☐ Thyroid Disorders
☐ Endometriosis	☐ Osteoporosis	☐ Tuberculosis
☐ Elevated Cholesterol	☐ Ovarian Cysts	☐ Uterine Fibroids
Sexually Transmitted Infections:		
☐ Herpes	☐ Gonorrhea	☐ Syphilis
☐ HPV/Genital Warts	☐ Chlamydia	☐ Other:

GRAPEVINE OBGYN

PATIENT HISTORY FORM

Name: Date:

Last First

Family History

	NO	YES	Family Member(s)
Breast Cancer	☐	☐	
Ovarian Cancer	☐	☐	
Colon Cancer	☐	☐	
Uterine Cancer	☐	☐	
Other Cancer	☐	☐	
Diabetes Mellitus	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	
High Cholesterol	☐	☐	
Other Problems:	☐	☐	

Obstetric History

How many of the following:					
Total Pregnancies	Term Deliveries	Preterm Deliveries	Miscarriages	Abortions	Living Children

Year	Sex	Weight	Delivery	Problems
	M / F		Vaginal / Cesarean	
	M / F		Vaginal / Cesarean	
	M / F		Vaginal / Cesarean	
	M / F		Vaginal / Cesarean	
	M / F		Vaginal / Cesarean	

Social History

Occupation:		
☐ Married (_____ years) ☐ Single	History of Recreational Drug Use? ☐ No ☐ Yes _____	Do you drink alcohol? How much? ☐ No ☐ Yes _____
☐ Divorced / Separated Do you Smoke? How much: ☐ No ☐ Yes _____	History of Domestic or Sexual Abuse? ☐ No ☐ Yes _____	Do you exercise regularly? ☐ No ☐ Yes _____

GRAPEVINE OBGYN

PATIENT HISTORY FORM

Name: Date:

Last First

Gynecologic History

First Day of Last Menstrual Period: _____

Age at First Period: _____

Regular Periods? ☐ Yes ☐ No

Cycle Length: _____ Days from Start to Start

Flow/Bleeding: ☐ Light ☐ Moderate ☐ Severe

Cramping: ☐ Light ☐ Moderate ☐ Severe

Have you ever had a mammogram? ☐ No ☐ Yes If Yes, when? _____

When was your last Pap smear? _____

History of abnormal Pap smears? ☐ No ☐ Yes If Yes, details? _____

Have you had any surgeries, biopsies, or other procedures to your cervix? ☐ No ☐ Yes If Yes, details _____

Do you have any of the following?

Loss of urine during Exercising/Coughing/Laughing/Sneezing? ☐ No ☐ Yes If Yes, do you wear pads? ☐ No ☐ Yes

Uncontrollable loss of urine at rest? ☐ No ☐ Yes

Burning during urination? ☐ No ☐ Yes

Blood in your urine? ☐ No ☐ Yes

If you are Menopausal:

☐ Hot Flashes ☐ Vaginal Dryness ☐ Mood Changes ☐ Disturbed Sleep

Thank you for taking the time to complete this questionnaire in advance of your visit. Please add any additional information you feel would be helpful in meeting your healthcare needs.

_____

_____

_____