Partridge Creek Obstetrics & Gynecology

19991 Hall Road, Suite 105
Macomb, MI 48044

Phone: 586-247-8609
Fax: 586-247-8615
e-Fax: 586-247-8613

HEALTH HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Medical History (any new from last visit): ☐None

☐Asthma
☐Arthritis
☐Heart Murmur
☐Heart Disease
☐Stroke
☐Epilepsy
☐Migraines
☐Lupus
☐Emphysema
☐Depression/Mental Illness
☐High Blood Pressure
☐HIV
☐Kidney Disease
☐Osteoporosis
☐Cholesterol
☐Thyroid Disease: **Hyperthyroid**
☐Thyroid Disease: **Hypothyroid**
☐Ovarian Cysts
☐Diabetes: **Type 1**
☐Diabetes: **Type 2**
☐Polycystic Ovaries (PCOS)
☐Endometriosis
☐Uterine Fibroids
☐Cancer (please specify type)
_____
☐Other: _____

Social History: ☐Single ☐Married ☐Divorced ☐Widowed ☐Female Partner ☐Male Partner

Occupation: _____ Student: ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No ☐Previously How many packs/cigarettes per day? _____

Do you use alcohol? ☐Yes ☐No ☐Previously How many drinks per day/week? _____

Do you use drugs? ☐Yes ☐No ☐Previously What kind? _____ How often? _____

OB/GYN History

First day of your last period: _____

Age of first period: _____ How many days between periods? _____ How long do your periods last? _____

Cramping during periods? ☐Yes ☐No Flow: ☐Heavy ☐Medium ☐Light Clots: ☐Yes ☐No
Pain level during periods (1= mild 10= severe) _____ out of 10

Are you currently sexually active?..... ☐Yes ☐No

Is your current sexual partner(s)?..... ☐Male ☐Female ☐Both

Are you currently pregnant?..... ☐Yes ☐No

Do you have a history of sexually transmitted diseases? ☐Yes ☐No Please specify type: _____

What are you currently using for contraception? ☐None _____

What have you used previously? ☐IUD ☐Pills ☐Condoms ☐Patch ☐Nuvaring ☐Other: _____

Date of last pap smear: _____ ☐Normal ☐Abnormal Date of last mammogram: _____ ☐Normal ☐Abnormal

Date of last colonoscopy: _____ ☐Normal ☐Abnormal Date of last bone density: _____ ☐Normal ☐Abnormal

How many times have you been pregnant? _____ Number of children? _____

Date of delivery	Weeks at delivery	C-Section/Vaginal	Male/Female	Baby's birth weight	Complications

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HEALTH HISTORY CONTINUED

Surgical History (any new from last visit) ☐None **Name:**_____

Date	Type of Surgery	Date	Type of Surgery

Medication (please include vitamins, over the counter medications) ☐None

Medication	Dosage (mg, IU)	How often you take

Allergies (please include medications, environmental, and food allergies) ☐None

Allergy	Reaction (hives, swelling, etc…)	Allergy	Reaction (hives, swelling, etc…)

Family Medical History (any new from last visit- please include relationship to you- i.e. parents, siblings, grandparents)

☐Diabetes: **Type 1** _____
☐Diabetes: **Type 2** _____
☐High Blood Pressure _____
☐Depression/Mental Illness _____
☐Thyroid Disease: **Hypothyroid** _____
☐Thyroid Disease: **Hyperthyroid** _____
☐Kidney Disease _____
☐Stroke _____
☐Osteoporosis _____
☐Lupus _____
☐Heart Disease _____
☐Emphysema _____
☐Breast Cancer _____
☐Colon Cancer _____
☐Ovarian Cancer _____
☐Other Cancer (please specify) _____
☐Other (please specify) _____

Review of Symptoms (please mark any symptoms or problems you are experiencing today) ☐No problems today

☐Tired/Fatigue
☐Loss of appetite
☐Bleeding from gums
☐Headache
☐Chest pain
☐Shortness of breath
☐Shortness of breath with exercise
☐Nausea
☐Frequent urination at night
☐Urinary Frequency
☐Urinary Urgency
☐Blood in Urine
☐Joint Pain
☐Loss of hair
☐Memory/concentration difficulty
☐Decreased libido (sex drive)
☐Ringing in ears
☐Vomiting
☐Blood in stool
☐Intolerance to cold
☐Intolerance to heat
☐Night sweats
☐Decreased hearing
☐Diarrhea
☐Incontinence
☐Anxiety
☐Difficulty sleeping
☐Weight loss
☐Weight gain
☐Lightheadedness
☐Breast Lumps
☐Breast tenderness
☐Nipple discharge
☐Constipation
☐Hemorrhoids
☐Heartburn

Concerns or problems you'd like to discuss today not listed above: _____