Partridge Creek Obstetrics & Gynecology

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HEALTH HISTORY

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

Medical History (any new from last visit): 1 None

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

Social History: 1Single 1 Married 1 Divorced 1 Widowed 1 Female Partner 1 Male Partner

Occupation: _____ Student: 1 Yes 1 No

Do you use tobacco? 1 Yes 1 No 1 Previously How many packs/cigarettes per day? _____

Do you use alcohol? 1 Yes 1 No 1 Previously How many drinks per day/week? _____

Do you use drugs? 1 Yes 1 No 1 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? 1 Yes 1 No Flow: 1 Heavy 1 Medium 1 Light Clots: 1 Yes 1 No
Pain level during periods (1= mild 10= severe) _____ out of 10

Are you currently sexually active?..... 1 Yes 1 No

Is your current sexual partner(s)?.....1 Male 1 Female 1 Both

Are you currently pregnant?..... 1 Yes 1 No

Do you have a history of sexually transmitted diseases? 1 Yes 1 No Please specify type: _____

What are you currently using for contraception? 1 None _____

What have you used previously? 1 IUD 1 Pills 1 Condoms 1 Patch 1 Nuvaring 1 Other: _____

Date of last pap smear: _____ 1 Normal 1 Abnormal Date of last mammogram: _____ 1 Normal 1 Abnormal

Date of last colonoscopy: _____ 1 Normal 1 Abnormal Date of last bone density: _____1 Normal 1 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

Surgical History (any new from last visit) 1 None **Name:**_____