IRMC
PHYSICIAN GROUP
THE COMMUNITY'S CHOICE

Personal Health History: OB/GYN

First Name: _____ **Last Name:** _____

What is the main reason for today's visit? _____

Please check off any current problems:

- ☐ Irregular Bleeding & Spotting
- ☐ Vaginal Discharge
- ☐ Leakage of Urine
- ☐ Frequent Urination
- ☐ Breast Problems (Pain, Mass, Discharge)
- ☐ Pain with or after Intercourse
- ☐ Blood in Urine
- ☐ Vaginal Dryness/ Irritation/ Rash
- ☐ Bleeding with/after Intercourse
- ☐ Vaginal Itching/ Burning
- ☐ Painful Urination
- ☐ Frequent Urination at Night
- ☐ Hot flushes or Night Sweats
- ☐ Excess Hair Growth or Acne
- ☐ Loss of Interest in Sex
- ☐ Mood Swings/ Irritability

First day of your last period:_____ **Age at 1st period:**_____ **Age at Menopause:**_____

Are your periods regular? Yes ☐ No ☐ **How often do they occur?** Every_____days

How long is your flow? ___days **Is your bleeding:** Light ☐ Moderate ☐ Heavy ☐ Many Clots ☐

Is your cramping: None ☐ Mild ☐ Moderate☐ Severe☐

Do you have pain/cramps between periods? Yes☐ No☐ **Are you sexually active?** Yes☐ No☐

How many partners?_____ **Are your partner(s):** Male☐ Female☐ Both☐

Have you/ your partner ever had an STD? Yes☐ No☐

Would you like to be screened for STDs? Yes ☐ No☐

What do you use for contraception? (pills, condoms, IUD, tubal/ vasectomy, etc)_____

Do you have a history of abnormal pap? Yes☐ No☐

When was your last pap test? _____Normal☐ Abnormal☐

When was your last Mammogram? _____Normal☐ Abnormal☐

When was your last colonoscopy? _____Normal☐ Abnormal☐

When was your last DEXA scan? _____Normal☐ Abnormal☐

Did you receive the HPV Vaccine? Yes☐ No☐ **Do you take calcium supplement?** Yes☐ No☐

Do you exercise regularly? Yes☐ No☐ **Do you follow a special diet?** Yes☐ No☐

Do you perform breast self-exams? Yes☐ No☐

Please list prior pregnancies/ deliveries and complications: None☐ Unchanged since last visit☐

M/D/Y:	Delivery Type:	Baby Weight:	Baby Gender:	Complications:	Location:

Please list medical problems: ☐ Unchanged since last visit

_____ _____ _____ _____ _____

Please list prior surgeries: ☐ Unchanged since last visit

_____ _____ _____ _____ _____

List any allergies to medications, iodine, or latex:_____

List all current medications and dosages:

_____ _____ _____ _____

_____ _____ _____ _____

Does anyone in your family have any of the following (Grandmother, Grandfather, Aunt, Uncle, Sister, Brother, Cousin, Son, Daughter. Please specify maternal or paternal)**:**

Disease	Family Affected	Disease	Family Affected
Blood clot (legs/lungs)		Colon Cancer	
Osteoporosis		Diabetes	
Heart Disease		High Blood Pressure	
Ovarian Cancer		Other:	
Uterine Cancer		Other:	
Breast Cancer		Other:	

Marital Status: _____ **Occupation:** _____

Do you smoke/ use tobacco? Yes☐ No☐ **How many packs per day?**_____ **For how long?**_____

Do you drink alcohol? Yes☐ No☐ **How many drinks per week?** _____

Have you ever used any other drugs? Yes☐ No☐ **What and when?**_____

Are you being hurt or abused? Yes☐ No☐ **Do you feel safe at home?** Yes☐ No☐

Please note any other symptoms that you currently have below:

General: _____ Eyes:_____ Ear/nose/throat:_____

Heart/chest:_____ Lungs:_____ Abdomen/ GI:_____

Musculoskeletal:_____ Skin:_____ Neurologic:_____

Mental Health:_____

Are there any other issues that you would like to discuss today?_____

Preferred Pharmacy:_____

Primary Care Provider:_____