

# HENDERSON OB/GYN

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## OBSTETRICAL HISTORY FORM

### I. Identifying Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Name of internist or family doctor: \_\_\_\_\_

Name of last obstetrician/gynecologist: \_\_\_\_\_

Partner's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Children's names: \_\_\_\_\_

List any other physicians or health care providers you see:

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### II: Medication History

List all medications that you take with the dose and timing:  None

Drug	Dose	Frequency	Reason for medication	Prescribing MD
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List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing:  None

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Allergies: List all adverse reactions or allergies you have to medications and what happened.  None

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**III. Surgical History**    None

List all surgeries you have had including cesarean delivery, breast augmentation, tonsillectomy, appendectomy, LEEP or Conization of the cervix, Cerclage.

Date	Operation	Diagnosis	Hospital/MD

**IV. Medical History**    None

Please list any medical problems that you have, the physician taking care of you and how they are treated.

Date	Medical problem	Medication or treatment	Physician

Have you had any hospitalization, injuries, fractures or motor vehicle accidents not listed elsewhere?    None

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Check if you have or have you ever had:

- |                          |                          |                          |                          |                              |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|
| Alcohol abuse            | <input type="checkbox"/> | Anesthetic reaction      | <input type="checkbox"/> | Bleeding disorder            | <input type="checkbox"/> |
| Asthma                   | <input type="checkbox"/> | Anemia                   | <input type="checkbox"/> | Chronic lung condition       | <input type="checkbox"/> |
| Blood clots              | <input type="checkbox"/> | Drug and substance abuse | <input type="checkbox"/> | Depression/anxiety           | <input type="checkbox"/> |
| Diabetes                 | <input type="checkbox"/> | Heart disease            | <input type="checkbox"/> | High blood pressure          | <input type="checkbox"/> |
| High cholesterol         | <input type="checkbox"/> | Hepatitis/Jaundice       | <input type="checkbox"/> | Lupus or autoimmune disorder | <input type="checkbox"/> |
| Irritable bowel syndrome | <input type="checkbox"/> | Kidney stones            | <input type="checkbox"/> | Hypothyroidism               | <input type="checkbox"/> |
| Seizure disorder         | <input type="checkbox"/> | Incompetent Cervix       | <input type="checkbox"/> | Stomach ulcers               | <input type="checkbox"/> |
| Mitral valve prolapse    | <input type="checkbox"/> | Transfusion reaction     | <input type="checkbox"/> | Eating disorder              | <input type="checkbox"/> |
| Cancer                   | <input type="checkbox"/> |                          |                          |                              |                          |

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. General Health**

Date/place of last pap smear:  None \_\_\_\_\_

Date/place of last mammogram:  None \_\_\_\_\_

How much alcohol do you drink/week?  None  Avg. less than 1/day  Avg. 1/day  Avg. more

Do you smoke?  Yes  No Amount/day \_\_\_\_\_ How many years \_\_\_\_\_

If you quit smoking, when did you stop?  
\_\_\_\_\_

Have you used marijuana or other drugs in the last 5 years?  Yes  No Type: \_\_\_\_\_

Have you been immunized or had the following?

Hepatitis A  yes  no Hepatitis B  yes  no

Chickenpox (Varicella)  yes  no  unknown Rubella (MMR)  yes  no  unknown

Date of last TB test: \_\_\_\_\_  positive  negative Last flu shot: \_\_\_\_\_

**VI. Gynecologic History**

Length of cycle from first day to first day each month: \_\_\_\_\_ days  Regular  Irregular

Average length of each period: \_\_\_\_\_  Heavy  Moderate  Light

Last Menstrual Period: \_\_\_\_\_

Please check if you have had the following:

Endometriosis  Fibroids  Pelvic adhesions

Herpes  Gonorrhea  Syphilis

Chlamydia  Condyloma (warts)  Abnormal pap smear

Trichomonas  HPV  Laser/Freezing of cervix

**Sexual history:**

Have you ever been sexually abused or assaulted?  Yes  No

Are you personally concerned about AIDS?  Yes  No

**Pregnancy history:**

Number of times pregnant \_\_\_\_\_ Full term births \_\_\_\_\_ Premature births \_\_\_\_\_ Elective termination \_\_\_\_\_

Miscarriages \_\_\_\_\_ Ectopic pregnancies \_\_\_\_\_ Adopted children \_\_\_\_\_ Step children \_\_\_\_\_ Twins \_\_\_\_\_

**Please list your pregnancy history:**

**Early pregnancy loss:**

Date	Miscarriage/number of weeks	Elective abortion/number of weeks

**Pregnancies lasting more than 20 weeks:**

Date	Length of pregnancy in weeks	Vaginal or C-section	Sex and weight	Hospital/Doctor	Complications

**FAMILY HISTORY:**     Adopted

	Current age	Age at death	Health problems or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sons	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Daughters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please Explain:

Which of your 1st degree family members have the following:

Breast cancer: \_\_\_\_\_ Ovarian cancer: \_\_\_\_\_  
 Colon cancer: \_\_\_\_\_ Other cancers: \_\_\_\_\_  
 Bleeding disorders: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
 Anesthesia Problems \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

