OB/GYN HEALTH HISTORY FORM

Willis Knighton Health

NAME: _____ AGE: _____ DOB: _____ DATE: _____

What is the reason for your visit: ☐ Annual Exam ☐ GYN Problem ☐ First OB Visit ☐ Contraception Management

☐ Follow up to hospital ☐ Consultation, referred by: _____ ☐ OTHER: _____

If you are here for a problem or other visit, what are your concerns? _____

_____

_____

Health Maintenance / Preventive Screening History:

BRCA Genetic Screening ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Colonoscopy ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Dexa Scan/Bone Density ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Mammogram ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Pap Smear History:

Pap smear ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

LEEP ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Colposcopy ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

History of HPV? ☐ Yes ☐ No If yes, date ____ / ____ / _____ Results: ☐ Normal ☐ Abnormal

Received HPV vaccine? ☐ Yes ☐ No If yes, date ____ / ____ / _____ ☐ Inj. 1 ☐ Inj. 2 ☐ Inj. 3

MEDICAL HISTORY:

Major Illness	YES	NO	WHEN	Major Illness	YES	NO	WHEN
Anemia	☐	☐		Hepatitis ☐ A ☐ B ☐ C	☐	☐	
Anxiety	☐	☐		High blood Pressure	☐	☐	
Arthritis/Joint Pain	☐	☐		High Cholesterol	☐	☐	
Asthma	☐	☐		History of Blood Transfusion	☐	☐	
Autoimmune Disorder	☐	☐		HIV	☐	☐	
Blood clot/DVT	☐	☐		Hyperthyroid	☐	☐	
Blood Transfusions	☐	☐		Hypothyroid	☐	☐	
Breast Cancer	☐	☐		IBS (irritable bowel syndrome)	☐	☐	
Cancer- list type: _____				Interstitial Cystitis	☐	☐	
Crohn's Disease	☐	☐		Kidney Disease	☐	☐	
Chronic Lung Disease	☐	☐		Migraines	☐	☐	
Depression	☐	☐		Osteopenia	☐	☐	
Diabetes Type 1	☐	☐		Osteoporosis	☐	☐	
Diabetes Type 2	☐	☐		Ovarian Cancer	☐	☐	
Fibrocystic Breast Disease	☐	☐		Ovarian Cysts	☐	☐	
Fibroids	☐	☐		Polycystic Ovarian Syndrome	☐	☐	
Fracture	☐	☐		Sexually Transmitted Disease	☐	☐	
GERD	☐	☐		Sickle Cell	☐	☐	
Heart Disease	☐	☐		Stroke	☐	☐	

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SOCIAL HISTORY:

Major Illness	YES	NO	How Often	Major Illness	YES	NO	How Often
Alcohol	☐	☐	_____	**Caffeine**	☐	☐	_____
Illicit Drug Use	☐	☐	_____	**Smoking**	☐	☐	_____
Vaping	☐	☐	_____	**Other**	☐	☐	_____

Past Surgical History: ☐ No past surgical history ☐ See List Attached **DATE**

Current Medications: ☐ **None** ☐ **SEE LIST ATTACHED**

If there is not sufficient space, please attach copy of medications list to this form.
Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs, supplements:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (*Food, Drugs, Environmental)* ☐ None ☐ Latex ☐ Iodine

Allergy	Interaction	Allergy	Interaction

Family Medical History*: Please indicate below significant medical problems of family members. Indicate which family member by completing the appropriate column and the AGE OF ONSET*: ☐ No Family History ☐ Adopted
Mother, Father, Brother, Sister, Grand Mother (Maternal), Grand Mother (Paternal), Grand Father (Maternal) Grand Father (Paternal), Aunt, Uncle

	RELATIVE (s)	AGE AT ONSET		RELATIVE (s)	AGE AT ONSET
Blood Clots/DVT			Breast Cancer		
Cervical Cancer			Colon Cancer		
Diabetes			Heart Disease		
High Risk Pregnancy			Hypertension		

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NAME:_____ AGE: _____ DOB:_____

Family Medical History Cont.	RELATIVE (s)	AGE AT ONSET		RELATIVE (s)	AGE AT ONSET
Ovarian Cancer			Stillborn/Fetal Demise		
Stroke			Uterine Cancer		
Other Diseases					

Menstrual History

Age first period began?	Date last period began?
Cycle Length (ex 28 days)	Irregular Periods?
Number of days of flow?	Bleeding/Spotting in between?
Heavy flow/Cramps/Clots?	

Birth Control

None	**YES**		**Nexplanon Implant**	**YES**	**Since**
Birth Control Pills	**YES**	**Since**	**Mirena IUD**	**YES**	**Since**
Paragard IUD	**YES**	**Since**	**Kyleena IUD**	**YES**	**Since**
Liletta IUD	**YES**	**Since**	**Surgical Tubal**	**YES**	**WHEN**
Skyla IUD	**YES**	**Since**	**Hysterectomy**	**YES**	**WHEN**
Condom	**YES**				
OTHER					

Pregnancy History

Date of Delivery	Weeks of Gestation	Sex	Weight	Vaginal	C-Section	VBAC	Complications

Other (Abortion, Ectopic, Miscarriage, Tubal Pregnancy, Other)

Type	Weeks of Gestation	DATE (Month & Year)

Other pertinent history or information

Reviewed by: DATE/TIME:

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