

## Western OB/GYN Ltd. Patient History Information

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

**REASON FOR TODAY'S VISIT** \_\_\_\_\_

**ALLERGIES:** Medication \_\_\_\_\_ Other Allergies \_\_\_\_\_

**CURRENT MEDICATIONS:** (include all prescription meds, vitamins & over-the-counter meds) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SURGICAL HISTORY:** \_\_\_\_\_  
 \_\_\_\_\_

**Family History:** Are you adopted? \_\_\_ Yes \_\_\_ No

Please indicate which family members have a history of the following medical conditions using **F**(Father), **M**(Mother), **B**(Brother), **S**(Sister), **G**(Grandparent):

Diabetes	Anesthesia problems	Ovarian cancer
Heart disease	Drug/Alcohol problems	Blood clots
Stroke (before age 50)	Osteoporosis	Other cancers (list location in body)
High cholesterol	Depression	
Bleeding problems	Breast cancer	

**Have you experienced any of the following symptoms in the past year?** (Please "x" all that apply):

<input type="checkbox"/> Frequent headache/migraines	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Bowel problems / pain	<input type="checkbox"/> Weight changes	<input type="checkbox"/> Diet changes
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Menstrual cycle changes	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Breast discharge	<input type="checkbox"/> Breast lump	<input type="checkbox"/> Breast pain
<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Vaginal infection / discharge	<input type="checkbox"/> Marital / Sexual problems
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Urinary dribbling / incontinence
<input type="checkbox"/> Frequency of urination	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Depression	<input type="checkbox"/> Pain with intercourse	

### Menstrual History

Age period began	# of days between periods	# of days of flow
# pads/tampons saturated on heaviest day	Bleeding between periods	Problems with menstruation
Cramps ( <i>circle</i> ) mild/moderate/severe	Date of last menstrual period	Age of menopause

### Obstetrical History:

Total # of pregnancies	# Full-term pregnancies	# Miscarriages
# Premature deliveries	# Elective abortions	# Living children

**Continued on second page**



