Tuality Obstetrics & Gynecology

TualityHealthcare
The right care. Right here.

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OB-1030 (1/16)

Welcome to our clinic. In order to provide you with the best care possible, we need to ask you about various aspects of your health history. We ask these questions of all of our clients, so some of them may not apply to you. If you feel uncertain about a question, please feel free to leave it blank. Your clinician will go over this form with you as well. Thank you for your time.

Name_____ Age_____ DOB_____ Date_____

Primary Care Provider:_____ Who referred you to our clinic?_____

Do you have any special questions or concerns today? If so, please describe_____

_____

MEDICAL HISTORY

Please check any of the following categories if you have ever had problems with:

❑ Nose / Sinus _____
❑ Headaches_____ ❑ Migraines_____
❑ Seizures _____
❑ Excessive Thirst _____
❑ Thyroid / Neck_____
❑ Breasts _____
❑ Heart problem_____ ❑ Chest pain _____
❑ High blood pressure_____
❑ History of abuse_____
(Physical / Emotional / Sexual)_____
❑ Mental health problems / Suicide attempts_____
❑ High Cholesterol _____

❑ Blood clots / Bleeding problems _____
❑ Stomach / Digestive problems _____
❑ Liver / Gall bladder_____
❑ Kidney / Urinary problems_____
❑ Joint / Muscle problems _____
❑ Anemia_____
❑ Genetic conditions _____
❑ Cancer_____
❑ Diabetes_____
❑ Breathing problems / Asthma_____
❑ TB / Postivie PPD _____
❑ Other _____

Any hospitalization (other than childbirth)?_____

Past Surgical History

List any surgeries and include dates: (Please include C-Sections and D&C's)

_____

_____

Obstetrical History

Number of Pregnancies _____ Number of Live Births _____ Number of Miscarriages / Abortions _____

Number of Premature Births_____ Number of Still Births_____ Number of Ectopic Pregnancies_____

Number of Living Children_____ Ages? _____

Any ❑ Diabetes or ❑ High blood pressure during pregnancy? Are you breastfeeding ❑ Yes ❑ No

Gynecologic History

Date of last Pap Smear: _____ Was it normal? ❑ Yes ❑ No

Ever had an abnormal Pap? ❑ Yes ❑ No Did it require any treatment? _____

Date of last mammogram: _____ Was it normal? ❑ Yes ❑ No

Ever had an abnormal mammogram? ❑ Yes ❑ No Did it require any treatment? _____

Are you sexually active? ❑ Yes ❑ No Are your sexual partners: ❑ Male ❑ Female ❑ Both

Age at first sexual intercourse: _____ Number of partners: _____

If you are menopausal, please skip this section and go to the next.

First day of your last menstrual period _____ Are your periods regular? ❑ Yes ❑ No

Age when periods started? _____

How long from the begininning of one to the beginning of the next? _____ How many days do they last? _____

Are they painful? ❑ Yes ❑ No Any PMS symptoms? ❑ Yes ❑ No Are you trying to get pregnant? ❑ Yes ❑ No

If not, what birth control method are you using? _____

For our menopausal patients:

How old were you when you had your last period? _____

Are you currently taking any Hormone Replacement Therapy? ❑ Yes ❑ No

If yes, list type and dose: _____

Any hot flashes, insomnia, vaginal dryness? ❑ Yes ❑ No Have you had a bone mineral density scan? ❑ Yes ❑ No

Are you having any of these symptoms now?

❑ Vaginal itching ❑ Vaginal irritation ❑ Vaginal Sores ❑ Unusual discharge

❑ Abnormal bleeding ❑ Pain with urination ❑ Pain with sexual activity ❑ Leaking Urine

Have you ever had:

❑ Chlamydia _____ ❑ Infertility problems _____

❑ Gonorrhea _____ ❑ Recurrent yeast infections _____

❑ Syphilis _____ ❑ Cancer of the cervix, uterus, vagina or ovaries _____

❑ Trichomoniasis _____ ❑ Uterine problems _____

❑ Herpes _____ ❑ Endometriosis _____

❑ Venereal warts / HPV _____ ❑ Ovarian Cysts _____

❑ Pelvic Inflammatory Disease _____ ❑ Other _____

Medications

Do you currently take any medications? ❑ Yes ❑ No Please list (including over the counter, prescriptions, herbal / vitamins)

_____

_____

_____

_____

Medication allergies: _____ Reaction: _____

_____ _____

_____ _____

_____ _____

Health / Lifestyle Habits

Have you ever smoked? ❑ Yes ❑ No Do you smoke now? ❑ Yes ❑ No If yes, how much per day?_____

How long?_____ Do you want to quit? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Yes ❑ No Number of drinks per week_____

Any current or past use of street drugs? ❑ Yes ❑ No What type?_____

Who do you live with?_____

Do you exercise? ❑ Yes ❑ No Type_____ How often?_____

Describe the type of diet you tend to eat (low fat, fast food etc.)?_____

Any weight concerns? ❑ Yes ❑ No History of eating disorders? ❑ Yes ❑ No

Family History

Does anyone in your family have: (M = Mother S = Sister F = Father B = Brother PGM = Paternal Grandmother PGF = Paternal Grandfather MGM = Maternal Grandmother MGF = Maternal Grandfather)

Diabetes:_____ High Cholesterol:_____ Stroke:_____

High Blood Pressure:_____ Blood Clots:_____ Heart attack before 50:_____

Cancer (please list type):_____

Thyroid Problems:_____ Bleeding Problems:_____ Alcohol / Drug Problems:_____

Osteoporosis: _____ Other:_____

MEDICAL HISTORY UPDATE	
	YEAR