INOVA

Obstetrics and Gynecology History Form

Name: ______________________________ **Age:**________ **Date:** ___________________

Reason for Visit:____

Allergies: ____

Primary Care Physician:______________________________**Referring Physician:**____________________

Race: _____Asian _____Black or African American ____Native American ____White Other_________

Language: _____English _____Spanish Other___________________________

Past Medical History: Please list all prior medical diagnosis

Past Surgical History: Please list all surgeries and dates

Please List Significant Medical Conditions in your Family, and who has/had them (breast cancer – mother, heart disease – grandfather, etc):

Medication Name	Dosage	Frequency

Marital Status: Married Divorced/Separated Single Widowed

Do you smoke? No Yes How many packs per day? ________________

Do you drink alcohol? No Yes How many drinks per week?________________

Do you currently or have you ever used illegal drugs? No Yes Please List:______________________

Do you exercise? No Yes How often?______________________

First Day of Last Menstrual Period	# of Days Between Menstrual Periods	# of Days Menstrual Period Lasts	Are your periods: Regular Irregular Flow: Light Moderate Heavy - # of pads/tampons per day____ Cramps: Mild Moderate Severe

Age at which you had your first menstrual period: ______________ Age at which you started Menopause ______________

Are you having any menstrual problems? No Yes, Describe ______________

If you are menopausal, are you having any vaginal bleeding? No Yes, Describe ______________

When was your last Pap Test?: ______________ Was it normal: Yes No

Have you ever had an abnormal Pap test?: No Yes, When ______________

Date of last mammogram: ______________ Date of last DEXA (bone density scan): ______________

Date of last colonoscopy: ______________ Date of last Tdap/Tetanus vaccine: ______________

Have you received the HPV vaccine? No Yes

Current Contraception: ______________ Do you use condoms? Yes No

What type(s) of birth control have you used in the past? IUD Oral Contraceptives Depo Provera Other__________

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

Do you want to be tested for sexually transmitted diseases (STDs)? Yes No

Number of sexual partners over lifetime: ______________ Number of times you have sex per month: ______________

Please Circle: Have you ever had any of the following STDs:

None Chlamydia Gonorrhea Venereal Warts Genital Herpes HPV Other______________

Pregnancy Dates	Vaginal Delivery or C-Section	Complications	Pregnancy Dates	Vaginal Delivery or C-Section	Complications

Number of:

Miscarriages:______________ Terminations: ______________ Living Children:______________

Review of Systems:

Please ☑ any of the following that you are currently experiencing problems with:

- ☐ Unexplained weight change
- ☐ Fever
- ☐ Dizzy spells/fainting
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Coughing
- ☐ Trouble breathing
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Heartburn/Indigestion
- ☐ Trouble with balance
- ☐ Severe joint/muscle pain
- ☐ Skin lesions
- ☐ Headaches
- ☐ Trouble sleeping
- ☐ Hot flashes/Night Sweats
- ☐ Difficulty concentrating
- ☐ Hair loss or thinning
- ☐ Excess body/facial hair
- ☐ Unusual fatigue
- ☐ Heat or cold intolerance
- ☐ Frequent bruising
- ☐ Domestic Violence
- ☐ Victim of sexual abuse
- ☐ Pain During Urination
- ☐ Increase in urinary frequency
- ☐ Blood In Urine
- ☐ Urinary Incontinence
- ☐ Pelvic Pain
- ☐ Vaginal discharge or odor
- ☐ Vulvar itching or rash
- ☐ Vaginal Dryness
- ☐ Premenstrual symptoms
- ☐ Breast Pain
- ☐ Pain or bleeding with sex
- ☐ Decreased sexual desire