

Associated Valley Obstetrics & Gynecology

Today's Date _____

Legal Name _____
First Middle Last Date of Birth _____ Age _____

Phone Numbers Work _____ Home _____ Cell _____
Social Security Number _____ Email _____

Although some of the information requested may not seem pertinent, it helps us provide for you and under some circumstances to identify illnesses. This information is confidential. It will only be released at your written request.

If you are a minor, we cannot discuss this or your care with your parents without your consent.

Family Health History - Has anyone in your family including grandparents; parents or siblings ever had the following. Please circle all that apply. Please indicate relationship.

Birth defects	Colon cancer	High cholesterol	Stroke
Blood clots in legs/lungs	Diabetes	Osteoporosis	Thyroid disease
Breast cancer	Heart disease	Ovarian cancer	Uterine cancer
Cervical cancer	High blood pressure	Skin cancer	

Medical History - Have you ever had any of the following? Please circle all that apply.

Recent Abdominal bloating	Depression Anxiety	High blood pressure	Osteoporosis/Osteopenia
Abdominal Pain	Diabetes	High cholesterol	Pelvic/hip injury
Alcohol abuse	Drug abuse	Liver disease	Stroke
Asthma	Epilepsy/seizures	Lung/tuberculosis	Thyroid disease
Bleeding disorder	Glaucoma	Mental health problems	Transfusions
Bowel disease/problems	Headaches	Migraine headaches	Ulcer
Breast cancer	Hearing problems	Multiple sclerosis	
Cancer (other)	Heart disease	Neurological problems	
Chicken pox	Hepatitis	New urinary symptoms	
Other _____			

Medication & Allergy History - Are you allergic to any of the following? Please circle all that apply.

Iodine	Latex	Penicillin	Sulfa
Other Antibiotics _____		Other _____	
Describe your reactions _____			
List all prescribed medicines you now take _____			
List all vitamins and herbs you take _____			

Surgery and Hospitalizations - Give year or your age when done.

Appendectomy _____	Cesarean section _____	Gall bladder _____	LEEP/Cervical Conization _____
Blood transfusions _____	D and C _____	Hysterectomy _____	Tonsillectomy _____
Breast surgery (any type) _____	Gyn Surgery (other) _____	Laparoscopy _____	Tubal ligation _____
Other hospitalizations _____			

Gynecologic History / Immunization History - Please provide dates where appropriate

Last pelvic exam _____	Last PAP smear _____	Your weight _____	Your height _____
Abnormal PAP smears ___Yes ___No		Type of treatment _____	
Date and place of last mammogram _____			
Have you had screen for colon cancer (50 years or older)			
Stool blood test, sigmoidoscopy or colonoscopy		___Yes ___No	
Have you had Genital herpes, Chlamydia, gonorrhea or pelvic inflammatory disease			
Do you currently have vaginal itching, odor or abnormal discharge		___Yes ___No	
Have you had your cholesterol checked in the past 3 years			
Have you had a tetanus shot within the last 10 years		___Yes ___No	
Have you had a Hepatitis B Vaccine (health care worker or under age 15)			
Have you had the HPV vaccine series (age 9-26)		___Yes ___No	

Menstrual History (if menstruating)

Date of last period _____	How old were you with your first period _____
Do you have bad cramps _____ Yes _____ No	Do you bleed between periods _____ Yes _____ No
Is heavy flow a problem _____ Yes _____ No	Are your periods prolonged more than nine days _____ Yes _____ No
Do you have PMS _____ Yes _____ No	Do you take medicine for cramps _____ Yes _____ No
Was the last period normal for you _____ Yes _____ No	Do periods/PMS keep you home _____ Yes _____ No
Do you skip periods _____ Yes _____ No	Spotting _____ Yes _____ No
Are your periods regular _____ Yes _____ No	Do you bleed after intercourse _____ Yes _____ No

Menopause History (if menopausal)

Do you have hot flashes _____ Yes _____ No	Have you ever used hormone replacement _____ Yes _____ No
Do you have vaginal dryness _____ Yes _____ No	Do you have problems with low sex drive _____ Yes _____ No
Do you have urinary frequency _____ Yes _____ No	Do you have loss of urine (incontinence) _____ Yes _____ No
Have you had a bone density test _____ Yes _____ No	

Pregnancy History (Please list sex, year of birth, weight and type of delivery)

Pregnancies _____ Full term deliveries _____ Preterm deliveries _____ Abortions _____ Miscarriages _____

Ectopic Pregnancies _____ Living Children _____

Did your mother take DES when pregnant with you _____ Yes _____ No

Have you had any complications with pregnancies or abortions _____ Yes _____ No

Have you had problems becoming pregnant _____ Yes _____ No

Sexual History (Complete any that apply to you)

Age you started having intercourse _____	Do you feel safe in your relationship _____ Yes _____ No
Do you have a male partner _____ Yes _____ No	Are you or your partner using birth control _____ Yes _____ No
Do you have a female partner _____ Yes _____ No	What type _____
Is your sexual activity satisfactory _____ Yes _____ No	Are you satisfied with your birth control method _____ Yes _____ No
Any pain with intercourse _____ Yes _____ No	Has your partner had a vasectomy _____ Yes _____ No
Do you have other sexual partners _____ Yes _____ No	Does your partner use a condom _____ Yes _____ No
Does your partner have other partners _____ Yes _____ No	Do you need information of safe sex practices _____ Yes _____ No
How many partners have you had	Do you wish to have HIV testing _____ Yes _____ No
Lifetime _____ Last Year _____	

Health Habits

Do you smoke _____ Yes _____ No	How much alcohol do you drink _____ Daily _____ yearly
Packs a day _____	Do you think you have a problem with alcohol _____ Yes _____ No
Have you smoked in the past _____ Yes _____ No	Do you wear seat belts when driving _____ Yes _____ No
Quit date _____	Do you exercise regularly _____ Yes _____ No
Do you use street drugs _____ Yes _____ No	
Have you in the past _____ Yes _____ No	
What kind(s) _____	
IV drug use _____ Yes _____ No	

Social History

Marital status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated _____ Living with _____

Current occupation _____

Who referred you to our office _____

Who is your primary care physician _____

Other doctors you see (general and specialists) _____

What brings you to our office today _____

Would you like a chaperone during your visit today _____ Yes _____ No