Williamsburg Obstetrics & Gynecology

MEDICAL HISTORY

Account #_____

Name _____ (_____) Date Completed _____
First Middle Last Maiden

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Birth date _____ Birthplace _____
Mo. / Day / Yr.

How do you prefer to be addressed? (Miss - Mrs. - Ms. - First Name/Nick Name)_____

Education: _____ Years High School _____ Years College Highest Degree Completed _____

Occupation _____ Place of Employment _____

MENSTRUAL HISTORY

Age you began menstruation _____ ☐ Regular ☐ Irregular First day of last menses _____
Mo. / Day

# of days from the first day of your period to the next _____ Duration _____

Pain with periods ☐ No ☐ Yes If yes, what do you do to relieve it? _____

Flow: ☐ Light to moderate ☐ Moderate to heavy ☐ Heavy to very heavy

Are you menopausal? ☐ No ☐ Yes If yes, are you taking hormones? ☐ No ☐ Yes _____
Medication(s)

Do you experience: ☐ Hot Flashes ☐ Insomnia ☐ Moodiness ☐ Vaginal Dryness/Irritation

Present Method of Birth Control:

- ☐ Condoms
- ☐ Diaphragm
- ☐ Sponge
- ☐ IUD
- ☐ Tubal Ligation
- ☐ Birth Control Pills - Name
- ☐ Rhythm Method (Natural Family Planning)
- ☐ Other

Are you satisfied with your current method of birth control? ☐ No ☐ Yes

Do you experience pain with intercourse? ☐ No ☐ Yes Are you satisfied with sex now? ☐ No ☐ Yes

PREGNANCY HISTORY

Have you ever been pregnant ☐ No ☐ Yes

- How many times _____
- How many babies born alive _____
- How many stillbirths _____
- How many miscarriages _____
- How many abortions _____
- Ectopic pregnancies _____

Date of last pregnancy _____

Have you ever had any complications with your pregnancies? ☐ No ☐ Yes

- Cesarean Section (how many) _____
- Premature labor (labor before 37 weeks) ☐ No ☐ Yes
- High blood pressure ☐ No ☐ Yes
- Diabetes ☐ No ☐ Yes
- Other, please describe _____

FAMILY HISTORY

MOTHER: Living? ☐ No ☐ Yes Age _____ Has your mother ever been diagnosed with Breast Cancer? ☐ No ☐ Yes
Ovarian Cancer? ☐ No ☐ Yes

Any other significant illnesses? _____

FATHER: Living? ☐ No ☐ Yes Age _____

Significant illnesses? _____

SIBLINGS?

Brother or Sister	Age	Significant Illnesses

Has a sister, grandmother, or aunt ever been diagnosed with Breast or Ovarian Cancer? ☐ No ☐ Yes

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes If yes, how much? _____ /day

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? _____

Do you use recreational drugs? ☐ No ☐ Yes If yes, how often? _____

Are you involved in an abusive relationship? ☐ No ☐ Yes

Would you like us to discuss this issue with you or provide you with further information? ☐ No ☐ Yes

Please list any other physician you have seen in the past for problems you still have _____

PERSONAL MEDICAL HISTORY

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Dosage	How Long?

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list _____

Date of last tetanus shot: _____

ARE YOU EXPERIENCING ANY PROBLEMS WITH: ***If yes, please describe***

-Your eyes, ears, nose, throat	☐ No ☐ Yes	
-Your heart (pain, palpitations, etc)	☐ No ☐ Yes	
-Your lungs (shortness of breath, cough)	☐ No ☐ Yes	
-Your stomach (pain, nausea, bloating, etc)	☐ No ☐ Yes	
-Your bowels(diarrhea, constipation, bleeding)	☐ No ☐ Yes	
-Headaches, migraines	☐ No ☐ Yes	
-Joint pain, muscle pain, back pain	☐ No ☐ Yes	
-Depression, anxiety, eating disorders, substance abuse	☐ No ☐ Yes	
-Urination	☐ No ☐ Yes	
-Involuntary loss of urine (when coughing or sneezing)	☐ No ☐ Yes	

HAVE YOU EVER BEEN DIAGNOSED AND/OR TREATED FOR ANY OF THE FOLLOWING:

Gonorrhea	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes
Syphilis	☐ No ☐ Yes	Condyloma (Venereal Warts)	☐ No ☐ Yes
Chlamydia	☐ No ☐ Yes	Herpes	☐ No ☐ Yes
AIDS	☐ No ☐ Yes	Pelvic Inflammatory Disease/Infection	☐ No ☐ Yes

Have you ever had an abnormal PAP? ☐ No ☐ Yes If so, please list date and treatment _____

Have you ever had a blood transfusion ☐ No ☐ Yes

THE FOLLOWING REPRESENT RISK FACTORS FOR AIDS (HIV)

- Multiple sex partners
- A sexual partner who is (was) Bi-sexual
- I.V. drug abuse
- A sexual partner who is (was) an IV drug abuser

Do you wish to further discuss risk factors for AIDS (HIV)? ☐ No ☐ Yes

PAST MEDICAL HISTORY

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD

Date	Surgery/Hospitalized For	Date	Surgery/Hospitalized For

Please describe any significant medical problems you have had in the past _____