Lifespan Physician Group – OB-GYN Associates
Women's Health History Form

Name: _____ Age: ____ Marital Status: _____
Referred by: _____ Reason for visit: _____

MEDICAL & FAMILY HISTORY

Have you or any members of your family had :

	YOU	YOUR FAMILY
High Cholesterol	☐	☐
Heart disease	☐	☐
High blood press.	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Thyroid disease	☐	☐
Intestinal problems	☐	☐
Breast problems	☐	☐
Bladder problems	☐	☐
AIDS (HIV)	☐	☐
Hepatitis	☐	☐
Blood disorder	☐	☐
Infertility	☐	☐
Endometriosis	☐	☐
Osteoporosis	☐	☐
Lupus	☐	☐
Blood transfusion	☐	
Seizures	☐	
Migraines	☐	
Depression	☐	
Domestic violence	☐	
Abnormal Pap smear	☐	
Abnormal mammogram	☐	
Genital warts	☐	
Herpes	☐	
Chlamydia	☐	
Gonorrhea	☐	
Syphilis	☐	
Sexual problems	☐	
DES Exposure	☐	

PREGNANCY HISTORY

of full-term births _____
# of premature births _____
# of miscarriages _____
# of terminations _____
# of living children _____

Please list all the **MEDICATIONS** you are currently taking including over the counter medications and vitamins :

_____
_____
_____
_____
_____

Please list any **ALLERGIES** to medications :

_____
_____
_____
_____

MENSTRUAL HISTORY

Age at first period _____
First day of last period _____
days between periods _____
days of flow _____
Any excessive bleeding? _____
Any excessive cramping? _____
Any bothersome discharge? _____
Any vaginal itching? _____
Date of last Pap smear _____
Date of last Mammogram _____

CONTRACEPTIVE HISTORY

	PRESENT	PAST
Birth control pill	☐	☐
IUD	☐	☐
Diaphragm	☐	☐
Condoms	☐	☐
Spermicides	☐	☐
Norplant	☐	☐
Depo-Provera	☐	☐
Vasectomy	☐	☐
Tubal ligation	☐	☐

HOSPITALIZATIONS

Please list any operations or serious illnesses requiring hospitalization:

Month/year Illness/Operation

_____
_____
_____
_____
_____
_____

LIFESTYLE

How many alcoholic drinks do you have a day? _____
How many cigarettes do you smoke a day ? _____
Do you use any street drugs like cocaine or marijuana? _____
How many caffeinated drinks do you have a day?_____
How many glasses of milk do you have a day? _____
Do you take Calcium supplements? __
How many times a week do you exercise?_____
Do you perform breast self-exam? _____
Do you feel that you are engaging in any risky sexual behavior?_____

Are you currently experiencing any **OTHER PROBLEMS** not mentioned above?

_____
_____
_____
_____
_____
_____