DATE_____

PENFIELD OBSTETRICS & GYNECOLOGY, LLP

PATIENT MEDICAL HISTORY

NAME_____ DOB_____ AGE_____ HEIGHT_____

MARITAL STATUS_____ FAMILY MD_____

HOME PHONE_____ OCCUPATION_____ WORK PHONE_____

NAME OF SPOUSE_____ OCCUPATION_____ PHONE_____

EMERGENCY CONTACT NAME & RELATIONSHIP_____ PHONE_____

A. MENSTRUAL HISTORY (complete this section even if you are post-menopausal or no longer have periods)

- AGE PERIOD BEGAN_____
- PERIODS OCCUR EVERY_____DAYS
- DURATION OF BLEEDING_____ DAYS
- BLEEDING/SPOTTING BETWEEN PERIODS? □ YES □ NO
- BLEEDING/SPOTTING AFTER INTERCOURSE? □ YES □ NO
- FIRST DAY OF LAST MENSTRUAL PERIOD (M/D/Y)_____
- PAIN WITH PERIODS? □ YES □ NO
- ARE YOU POSTMENOPAUSAL? □ YES □ NO
- HAVE YOU HAD A HYSTERECTOMY? □ NO □ YES YEAR_____

B. OBSTETRIC HISTORY (list all pregnancies including miscarriages, stillbirths, ectopics (tubal), & terminations)

□ CHECK HERE IF YOU HAVE NEVER BEEN PREGNANT □ CHECK HERE IF YOU HAVE ADOPTED CHILDREN

YEAR	M/F	WEIGHT	TYPE OF DELIVERY	LENGTH OF PREGNANCY	COMPLICATIONS (Preterm Labor, Diabetes, High Blood Pressure, etc.)

C. SEXUAL HISTORY

- DO YOU CURRENTLY HAVE A SEXUAL PARTNER? □ YES □ NO
- IF YES, □ MALE OR □ FEMALE PARTNER?
- DO YOU HAVE PAIN WITH INTERCOURSE? □ YES □ NO
- DO YOU HAVE ANY STD CONCERNS TODAY? □ YES □ NO
- WHAT BIRTH CONTROL METHOD(S) DO YOU CURRENTLY USE? □ NONE □ CONDOMS □ BIRTH CONTROL PILLS □ DEPO PROVERA □ DIAPHRAGM □ NATURAL FAMILY PLANNING □ TUBAL LIGATION □ PARTNER VASECTOMY □ MIRENA IUD □ SKYLA IUD □ PARAGARD IUD □ IMPLANON/NEXPLANON DEVICE □ OTHER_____

D. PAST OB/GYN SURGERIES

CHECK ALL THAT APPLY: □ NONE

	SURGERY	YEAR		SURGERY	YEAR
	D&C HYSTEROSCOPY			LEFT OVARY REMOVED	
	ABLATION (NOVASURE)			RIGHT OVARY REMOVED	
	LAPAROSCOPY			REPAIR SURGERY FOR PELVIC ORGAN PROLAPSE	
	HYSTERECTOMY (VAGINAL)			SURGERY FOR URINARY INCONTINENCE	
	HYSTERECTOMY (ABDOMINAL)			CESAREAN SECTION	
	HYSTERECTOMY (LAPAROSCOPIC)			TUBAL LIGATION	
	OVARIAN CYSTECTOMY			HYSTEROSALPINGOGRAM (HSG) – INFERTILITY	

OTHER (specify type & year)_____

NAME & DOB:_____

E. SURGICAL HISTORY (Not OB/GYN)

LIST ALL NON OB/GYN SURGERIES AND THE YEAR PERFORMED: □ NONE

SURGERY	YEAR

F. GYN HISTORY

- DATE OF LAST PAP SMEAR_____ ▪ HAVE YOU HAD ABNORMAL PAP SMEARS? □ YES □ NO
- IF YES, WHAT TREATMENTS HAVE YOU HAD? □ CRYOTHERAPY □ LASER □ CONE BIOPSY □ LOOP EXCISION (LEEP)
- DATE OF LAST MAMMOGRAM_____ □ NORMAL □ ABNORMAL
- DATE OF LAST DEXA SCAN_____ □ NORMAL □ OSTEOPENIA □ OSTEOPOROSIS
- DATE OF LAST COLONOSCOPY_____ □ NORMAL □ ABNORMAL
- CHECK IF YOU'VE HAD ANY OF THE FOLLOWING: □ NONE □ GENITAL WARTS □ GENITAL HERPES □ SYPHILIS

□ PELVIC INFLAMMATORY DISEASE □ ENDOMETRIOSIS □ CHLAMYDIA □ GONORRHEA □ VAGINAL INFECTIONS

G. PAST MEDICAL HISTORY

CHECK ALL THAT APPLY: □ NONE

	ARTHRITIS		RHEUMATIC FEVER		LIVER DISEASE (INCLUDING HEPATITIS)
	DIABETES:		HEARING DEFECTS		EPILEPSY
	□ DIET CONTROLLED		GERMAN MEASLES (3 DAY)		ANEMIA
	□ PILL CONTROLLED		BLOOD DISORDERS		THYROID DISEASE
	□ INSULIN CONTROLLED		BLOOD TRANSFUSIONS		ASTHMA
	HIGH BLOOD PRESSURE		CHICKENPOX		EMPHYSEMA
	HEART DISEASE		ANXIETY		BRONCHITIS
	KIDNEY DISEASE		DEPRESSION		HIV+
	GALLSTONES		PHLEBITIS		EATING DISORDER
	NEUROLOGICAL PROBLEMS		HEADACHES		JAUNDICE
	TUBERCULOSIS		HIGH CHOLESTEROL		ABNORMAL PAP SMEAR
	SEXUAL PROBLEMS		HPV VACCINE		KIDNEY OR BLADDER INFECTIONS
	MITRAL VALVE PROLAPSE		HISTORY OF CANCER (list):		

OTHER_____

H. CURRENT SYMPTOMS

HAVE YOU RECENTLY EXPERIENCED: □ NONE

	WEIGHT LOSS		HOT FLASHES
	WEIGHT GAIN		NIPPLE DISCHARGE
	FATIGUE		DEPRESSION
	HAIR GROWTH		ANXIETY
	HAIR LOSS		CHANGE IN LIBIDO
	CHANGE IN URINARY/BOWEL FUNCTION		INSOMNIA

NAME & DOB:_____

I. CURRENT MEDICATIONS

▪ LIST CURRENT PRESCRIPTIONS AND/OR OVER-THE-COUNTER MEDICATIONS (INCLUDE DOSAGE)

MEDICATION	DOSE	FREQUENCY

J. ALLERGIES

□ NO KNOWN DRUG ALLERGIES ▪ **ALLERGIC TO LATEX?** □ YES □ NO

DRUG ALLERGY (ie: Penicillin, Cipro, Flagyl, etc)	REACTION (ie: Hives, Swelling, Rash, etc)

▪ LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES _____

_____

K. HEALTH HABITS

DO YOU CURRENTLY:

▪ DRINK ALCOHOL? □ NO □ YES DRINKS PER WEEK_____ ▪ SMOKE? □ NO □ YES PACKS PER DAY_____

▪ ARE YOU A FORMER SMOKER? □ NO □ YES ▪ USE ILLEGAL DRUGS? □ NO □ YES_____

▪ WEAR GLASSES? □ NO □YES ▪ WEAR CONTACTS? □ NO □ YES ▪ HAVE ROUTINE DENTAL EXAMS? □ NO □ YES

▪ EXERCISE? □ NO □ YES TYPE_____ DAYS PER WEEK_____

▪ PERFORM MONTHLY SELF BREAST EXAMS? □ NO □ YES ▪ WEAR A SEAT BELT? □ NO □ YES

L. FAMILY HISTORY

CHECK IF ANY BLOOD RELATIVES HAVE/HAD THE FOLLOWING ILLNESSES: □ CHECK HERE IF YOU WERE ADOPTED

	CANCER	RELATIVE/AGE OF DIAGNOSIS		ILLNESS	RELATIVE
	BREAST CANCER			HEART DISEASE	
	OVARIAN CANCER			HIGH BLOOD PRESSURE	
	ENDOMETRIAL (UTERINE) CANCER			HIGH CHOLESTEROL	
	COLON CANCER			DIABETES	
	OTHER CANCER_____			STROKE	

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN SIGNATURE____ DATE__________________________