# LEGENDS OBSTETRICS AND GYNECOLOGY
# PATIENT HISTORY FORMS

Welcome to our practice. The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____ Date_____

Primary Care Physician_____ Age_____ Birth Date_____

Marital Status: S M Sep W D SSP (same sex partner)

## FAMILY HISTORY:

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or PGM- Maternal or Paternal), Aunt (A), Uncle (U):

| No | Yes | Who | | No | Yes | Who | | No | Yes | Who | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | _____ | Diabetes | ☐ | ☐ | _____ | High blood pressure | ☐ | ☐ | _____ | Sickle cell disease |
| ☐ | ☐ | _____ | Heart attack | ☐ | ☐ | _____ | Stroke | ☐ | ☐ | _____ | Birth defects/hereditary disease |
| ☐ | ☐ | _____ | Cancer | ☐ | ☐ | _____ | Blood clots (leg / lung) | ☐ | ☐ | _____ | Osteoporosis |
| ☐ | ☐ | _____ | Tuberculosis | ☐ | ☐ | _____ | Thyroid disease | ☐ | ☐ | _____ | Other_____ |

## MEDICAL HISTORY:

Do you have, or have you ever had, any of the following:

| No | Yes | Now | | No | Yes | Now | | No | Yes | Now | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | Sickle cell trait or disease | ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | Kidney problem |
| ☐ | ☐ | ☐ | Heart disease | ☐ | ☐ | ☐ | Thyroid problem | ☐ | ☐ | ☐ | Recurrent bladder infection (>3 per year) |
| ☐ | ☐ | ☐ | Heart murmur | ☐ | ☐ | ☐ | Severe depression | ☐ | ☐ | ☐ | IBS |
| ☐ | ☐ | ☐ | Do you take antibiotics for dental work? | ☐ | ☐ | ☐ | Psychiatric problems | ☐ | ☐ | ☐ | GERD (reflux) |
| | | | | ☐ | ☐ | ☐ | Numbness or tingling of extremities | ☐ | ☐ | ☐ | Colitis |
| ☐ | ☐ | ☐ | High blood pressure | | | | | ☐ | ☐ | ☐ | Liver disease/jaundice |
| ☐ | ☐ | ☐ | Varicose veins/phlebitis | ☐ | ☐ | ☐ | Epilepsy/seizures | ☐ | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | ☐ | Blood clots (legs/ lungs) | ☐ | ☐ | ☐ | Stroke | ☐ | ☐ | ☐ | Mononucleosis |
| ☐ | ☐ | ☐ | Bleeding disorder | ☐ | ☐ | ☐ | Frequent headaches | ☐ | ☐ | ☐ | Asthma |
| ☐ | ☐ | ☐ | High cholesterol, | ☐ | ☐ | ☐ | Migraine headaches | ☐ | ☐ | ☐ | Gall bladder problem |
| ☐ | ☐ | ☐ | Positive tuberculosis test (PPD) | ☐ | ☐ | ☐ | Rubella infection or immunization (German measles) | ☐ | ☐ | ☐ | Any other illness (please list) |
| ☐ | ☐ | ☐ | HIV exposure | | | | | | | | |
| ☐ | ☐ | ☐ | Cancer | | | | | | | | |
| ☐ | ☐ | ☐ | Breast disease | ☐ | ☐ | ☐ | Chicken pox or immunization | | | | |

_____

_____

Date of last tetanus shot (month/year)_____

## MEDICATIONS

List all medications you are using by name and dosage (include vitamins, calcium and herbs)

_____

_____

_____

_____

_____

_____

## ALLERGIES

☐ No known allergies to medications

Allergies to medications: Please list name of drug and reaction:

_____

_____

Are you allergic to: Copper ☐ Yes ☐ No
Rubber/latex ☐ Yes ☐ No
Iodine or shellfish ☐ Yes ☐ No

## SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

| Date | Type | Date | Type |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## MENSTRUAL HISTORY

Age period started_____ Date of last period_____

Periods come every _____ days and last for _____ days. Periods are ☐ regular ☐ irregular ☐ light ☐ moderate ☐ heavy.

Do you have cramps with your period? ☐ No ☐ Yes If yes, what do you do for the discomfort_____

Do you bleed between periods? ☐ No ☐ Yes Do you ever use tampons? ☐ No ☐ Yes

## GYN HISTORY

Date of last Pap smear_____ Date of last mammogram_____ Date of last DEXA Scan_____

(PLEASE TURN PAGE OVER)

Patient Name_____Today's Date_____

## PREGNANCY HISTORY

☐ Never been pregnant  Have you ever had difficulty becoming pregnant? ☐ No ☐ Yes ☐ N/A

List number of: Pregnancies_____ Living children_____ Abortions_____ Miscarriages_____

| Date of Pregnancies (date of delivery or termination) | Type of Delivery (Vaginal/C-section/VBAC/Termination/Miscarriage) | Sex |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## CONTRACEPTION

Total number of sexual partners in your lifetime_____

Age of first intercourse_____ Are you sexually active at present? ☐ No ☐ Yes

Yes

If you have ever used birth control, please list all methods used in the past:

| Birth control method | Date(s) of use | Any problems with this method (yes/no) |
|---|---|---|
| | | |
| | | |
| | | |

Present method_____ Used since_____ Any problems (yes/no)_____

## SOCIAL/PERSONAL HISTORY

Highest year of school completed: 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____City/Country of Birth_____

Occupation_____Employer_____

Present weight is: ☐ Satisfactory ☐ Unsatisfactory  Present weight is: ☐ About the same as a year ago ☐ More ☐ Less

Caffeine: Average #cups coffee/day _____ tea_____ caffeinated soda_____

Calcium: ☐ No ☐ Yes # servings/day (milk, cottage cheese, ice cream, yogurt)_____

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Currently smoke _____packs/day for how many years_____

Marijuana use: ☐ No ☐ Yes  Other street drugs: ☐ No ☐ Yes

What?_____

Do you feel you have a problem? ☐ No ☐ Yes

Alcohol: # drinks per week (beer, wine, liquor) _____ Do you feel you have a drinking problem? ☐ No ☐ Yes

How many drinks does it take to feel an effect?_____ Has anyone ever told you that you drink too much? ☐ No ☐ Yes

Have you ever been in treatment for alcohol problems? ☐ No ☐ Yes

What do you do for exercise?

Type/Frequency:_____ Have you been exposed to toxic substances? ☐ No ☐ Yes If so, what_____

Have you ever been physically, sexually, or emotionally abused? ☐ No ☐ Yes

Do you perform monthly breast self exams (BSE)? ☐ No ☐ Yes  Do you use seat belts ☐ No ☐ Yes

Are you interested in HIV (AIDS) testing? ☐ No ☐ Yes

Sex: what questions do you have?_____

What concerns do you have to discuss with your health provider?_____