

**BEND OBSTETRICS & GYNECOLOGY, LLC**

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**HEALTH HISTORY FORM**

Name:		Age:	Birthday:
Home Phone:		Work Phone:	
Primary Physician:		Physician that sent you:	
Reason for visit today: _____ _____ _____			
Medication:		Allergies:	

**Gynecologic History**

Age when menses started: \_\_\_\_ First day of last menstrual period:\_\_\_\_ How many days does it last:\_\_\_\_  
Period occurs every <21 days: \_\_\_\_ 21-30 days: \_\_\_\_ 30-35 days: \_\_\_\_ >35 days: \_\_\_\_  
Do you have menstrual cramps/pain?: \_\_\_\_ How severe: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_  
Do you ever bleed between periods?: \_\_\_\_ After intercourse: \_\_\_\_  
What do you use for contraception: \_\_\_\_\_  
Have you ever had:  
\_\_\_\_ Fibroids      \_\_\_\_ Ovarian cysts      \_\_\_\_ Vaginal dryness/itching  
\_\_\_\_ Endometriosis      \_\_\_\_ Pelvic inflammatory disease      \_\_\_\_ Hot flashes  
\_\_\_\_ Genital herpes      \_\_\_\_ Genital warts      \_\_\_\_ Yeast infection  
\_\_\_\_ Gonorrhea      \_\_\_\_ Syphilis      \_\_\_\_ Bacterial vaginosis  
\_\_\_\_ Chlamydia      \_\_\_\_ Mood swings  
Have you gone through menopause: No \_\_\_\_ Yes \_\_\_\_ What age? \_\_\_\_  
Date of last pap smear: \_\_\_\_\_ Normal?: Yes \_\_\_\_ No \_\_\_\_  
Have you ever had an abnormal pap smear?: Yes \_\_\_\_ No \_\_\_\_ Did you have: cyro colpo leep  
Date of last mammogram: \_\_\_\_\_ Normal?: Yes \_\_\_\_ No \_\_\_\_ Self breast exam? Yes \_\_\_\_ No \_\_\_\_

**Sexual History**

Are you sexually active?: Yes \_\_\_\_ No \_\_\_\_ Do you ever have pain with intercourse?: Yes \_\_\_\_ No \_\_\_\_  
Is your sex life satisfactory?: Yes \_\_\_\_ No \_\_\_\_ Sexual preference: Male \_\_\_\_ Female \_\_\_\_  
Any history of physical, emotional or sexual abuse Yes \_\_\_\_ No \_\_\_\_

**Social History**

Smoke: No \_\_\_\_ Yes \_\_\_\_ How much?: \_\_\_\_\_ Number of year?: \_\_\_\_\_  
Drink alcohol: No \_\_\_\_ Yes \_\_\_\_ How much per week?: \_\_\_\_\_ Seat belt?: Yes \_\_\_\_ No \_\_\_\_  
Drink beverage with caffeine: Yes \_\_\_\_ No \_\_\_\_ How much per day?: \_\_\_\_\_  
Use street drugs?: No \_\_\_\_ Yes \_\_\_\_  
Do you exercise regularly?: Yes \_\_\_\_ No \_\_\_\_ Describe: \_\_\_\_\_

Urinary Problems: (Do you have)

<input type="checkbox"/> Urine loss with cough	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Urine loss with urgency	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> To get up at night to urinate
<input type="checkbox"/> Urinary urgency	<input type="checkbox"/> Bladder infection	<input type="checkbox"/> To wear incontinence products
<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Uncontrollable loss of stool

Obstetrical History:

Total number of pregnancies \_\_\_\_\_ Number of living children \_\_\_\_\_ Number of miscarriages \_\_\_\_\_  
 Ectopic pregnancies \_\_\_\_\_ Terminations \_\_\_\_\_ Difficulty getting pregnant \_\_\_\_\_  
 Pregnancy complications \_\_\_\_\_

Infant Weight	Type of Delivery Vaginal or C-Section	Infant Weight	Type of Delivery Vaginal or C-Section

Do you have to take antibiotics before going to the dentist or having a procedure? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been vaccinated for Pneumonia? Yes \_\_\_\_\_ No \_\_\_\_\_

Medical History

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Thyroid

Surgical History

Year	Operation	Hospital

Family History

<input type="checkbox"/> Breast cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Uterine cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizure disorders
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Psychiatric disorders

Have you recently had or experienced:

<input type="checkbox"/> Constipation	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Weakness/Numbness
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Soiling pants with BM	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Abnormal hair growth	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Change in vision	<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Sudden weight change	<input type="checkbox"/> Change in hearing	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Depression	<input type="checkbox"/> Difficulty sleeping	

Physician Signature

Date

Patient Signature

Date