

SWEDISH COVENANT MEDICAL GROUP

Personal Health History Form Obstetrics and Gynecology

PATIENT LABEL

PATIENT NAME: _____
 PRIMARY DOCTOR: _____
 REFERRED BY: _____

Reason for today's visit: _____

PERSONAL INFORMATION:

Marital Status: Married Single Divorced Widowed
 Living with domestic partner
 Current or most recent occupation: _____

Medications: _____

 Allergies: _____

GYNECOLOGICAL HISTORY:

First day of your last menstrual period: ____/____/____
 Age of your first period: _____
 Length of your period: _____ (Number of bleeding days) Number of days between each period: _____
 Have you had any menstrual problems? No Yes If yes, explain: _____
 Are you in a sexual relationship? No Yes
 Are there any sexual problems? No Yes If yes, explain: _____
 Sexual partners are: Men Women Both
 Age at first intercourse: _____ Total number of sexual partners in your lifetime: _____
 Method of birth control: Presently _____ In the Past _____
 Date of your last Pap test: : ____/____/____
 Results: Normal Abnormal (Please circle one) If abnormal, explain: _____
 Have you ever had an abnormal Pap test? No Yes If yes, explain: _____
 Date of last mammogram: ____/____/____ Any breast biopsies?: No Yes
 Date of last bone scan: ____/____/____ Date of last flu shot: ____/____/____
 Date of colonoscopy: ____/____/____ Did you receive the HPV vaccine? Yes No

OBSTETRIC HISTORY:

	Number		Number
Pregnancies		Miscarriages	
Full term births		Abortions	
Preterm births (< 37 weeks)		Ectopic/Tubal pregnancies	
Vaginal births		Living children	
Cesareans		Complications: No Yes, specify:	

MEDICAL HISTORY:

Illness	No	Yes	Illness	No	Yes
Diabetes			Heart disease		
High blood pressure			Stroke		
Sexually transmitted infections			Headaches/Migraines		
Osteoporosis/Bone disease			Seizures		
Thyroid disease			Asthma/Lung disease		

Illness	No	Yes	Illness	No	Yes
Urinary tract infections/Bladder problems			Kidney infections/Stones		
Blood clots in lungs or legs			Ulcers/Reflux		
Depression/Anxiety			Bowel Problems		
Cancer			Hepatitis/Liver disease		
Anemia			Other, specify: _____		

SURGICAL HISTORY: None

Date	Surgery	Any Complications

SOCIAL HISTORY:

	No	Yes		
Tobacco: present or past use (circle)			Packs per day:	Years of use: Year Quit:
Alcohol			Drinks per day:	Drinks per week:
Drugs			Type of drug:	How used:
Diet/Herbal/Vitamin supplements			Type:	Dose:
Have you ever been sexually, physically or verbally abused? (Please circle)			By whom?	Currently?

FAMILY HISTORY: (e.g., mother, father, brother, sister, son, daughter)

	No	Yes	Relationship		No	Yes	Relationship
Breast cancer				Stroke			
Colon cancer				Heart disease			
Ovarian cancer				High blood pressure			
Uterine cancer				High cholesterol			
Other cancer, specify:				Birth defects or mental retardation			
Blood clots in legs or lungs				Alcoholism or drug abuse, specify:			
Osteoporosis				Dementia			
Diabetes				Other			

REVIEW OF SYSTEMS: (Please check if you are experiencing any of the following or add additional problems)

1. Constitutional	<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Memory loss
2. Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations or irregular heartbeat <input type="checkbox"/> Leg swelling
3. Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing
4. Gastrointestinal	<input type="checkbox"/> Bloody stool <input type="checkbox"/> Involuntary loss of gas or stool <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation
5. Genitourinary	<input type="checkbox"/> Frequency of urination <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Decreased libido <input type="checkbox"/> Involuntary loss of urine <input type="checkbox"/> Abnormal vaginal discharge <input type="checkbox"/> Painful sex <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Vaginal bulge <input type="checkbox"/> Postmenopausal bleeding
6. Musculoskeletal	<input type="checkbox"/> Back pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Painful joints
7. Skin	<input type="checkbox"/> Bruising <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Sores
8. Neurologic	<input type="checkbox"/> Dizziness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors
9. Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Homicidal thoughts
10. Endocrine	<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Night sweats

Patient Signature _____ Date / / _____ Physician Signature _____ Date / / _____