West Coast Ob/Gyn, Inc.

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Patient Name:_____ Date:_____
Date of Birth:_____ Age:_____ Marital Status:_____
Allergies:_____Occupation:_____
Problems you would like to discuss today:_____

_____

Gynecological History

Menstrual History:

First day of last period: _____
Frequency of periods: _____days
Length of periods: _____days
# of pads/tampons used on heaviest days:____

Pap Smears:

Date of last Pap Smear: _____
Results of last Pap Smear: _____

Birth Control:

Type Used: _____

Breasts:

Date of last Mammogram: _____
Results of last Mammogram: _____

Have you ever experienced the following?

	No	Yes	Details / Dates
Irregular Periods	☐	☐	_____
Bleeding Between Periods	☐	☐	_____
Bleeding after intercourse	☐	☐	_____
Large clots with periods	☐	☐	_____
Abnormal Pap Smears	☐	☐	_____
Breast aspiration or biopsy	☐	☐	_____
Infertility treatment	☐	☐	_____
Sexually transmitted disease (Herpes, Warts, Gonorrhea, Chlamydia, Pelvic Infection)	☐	☐	_____
Do you want to be tested for sexually transmitted diseases?	☐	☐	_____
Pain or problems with intercourse	☐	☐	_____
Problems with unexpected urine loss	☐	☐	_____
Endometriosis	☐	☐	_____
Fibroids	☐	☐	_____
Ovarian Cysts	☐	☐	_____

Are you currently in a sexual relationship?

Opposite Sex	☐	☐	_____
Same Sex	☐	☐	_____
Both Sexes	☐	☐	_____

Obstetrical History: List the date and outcome of all pregnancies, including miscarriages and abortions

DATE	# OF WEEKS	BIRTH WEIGHT	TYPE OF DELIVERY	PRETERM (Y/N)	COMMENTS/ COMPLICATIONS

Surgical History: List the date and name of all prior operations

_____

_____

Medical History: Have you every had any of the following? (Please check all that apply)

Cancer ☐ Yes ☐ No What type of Cancer? _____

Heart Disease ☐ Heart murmur ☐ Heart Attack ☐ Chest Pain
☐ High blood pressure ☐ Palpitations (irregular heart beat)

Lung Disease ☐ Shortness of breath ☐ Emphysema ☐ Asthma ☐ Tuberculosis ☐ Sleep Apnea

Liver Disease ☐ Hepatitis ☐ Yellow Jaundice

Kidney Disease ☐ Urinary tract infections ☐ Kidney infections

Gastrointestinal ☐ Ulcers ☐ Bloody Stools ☐ Chronic Constipation /Diarrhea

Nervous System ☐ Strokes ☐ Nerve Paralysis ☐ Seizures ☐ Fainting
☐ Depression ☐ Eating Disorders

Blood Disorders ☐ Bleeding disorders ☐ Easy bruising ☐Anemia ☐ Sickle Cell
☐ Blood clots in legs or lungs

Metabolic Disease ☐ Thyroid Disease ☐ Diabetes

Muscle & Bone ☐ Arthritis ☐ Osteoporosis ☐ Constant back pain

Do you drink alcohol?_____ How much? _____

Do you smoke?_____ How much? _____

Do you use any recreational drugs?____ Which ones? _____

Any problems with alcohol or drugs? _____

Any history of an abusive relationship? _____

Do you wish to discuss your HIV (AIDS) risk? _____

Medications: List all medications and dosages used on a regular basis including over the counter.

Medication	**Dosages**	**Medication**	**Dosage**

Family History: Any family member with the following problems?

	No	**Yes**	**Relationship**
Cancer of the Breast	☐	☐	_____
Cancer of the Ovary	☐	☐	_____
Cancer of the Colon	☐	☐	_____
Cancer- other types	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Disease of Heart Attack	☐	☐	_____
Diabetes	☐	☐	_____
Stroke	☐	☐	_____
Blood Clot in Lungs or Legs	☐	☐	_____
Bleeding Tendency	☐	☐	_____

Signature:_____