ASSOCIATES FOR WOMEN'S HEALTH OB/GYN HEALTH HISTORY

These are some very personal questions. Please provide us with complete and accurate information so we can provide you with the best possible health care.

What is the reason for your visit today? _____.

How old were you when you had your first period? _____.

Menstrual History: Age of onset_____ Regular ___ Irregular ____ Heavy Bleeding _____Light Bleeding___
Cramps: yes/ No. Cycle: ___ to ___ days. Duration: ____ to ___ days. # Of pads/tampons used on heaviest day__

How old were you when you had your first sexual encounter_____? Sexual preference: please circle Heterosexual, Homosexual, and Bisexual. How many partners have you had? _____ Length with present Partner: _____

Contraception: (circle all methods you have used) Pills, Condoms, Spermicides, Diaphragm, Withdrawal, IUD (paragard, Mirena), Sponge, Implanon, Vasectomy, Tubal Ligation, Other: _____

Allergies: _____ **Surgeries/ Illnesses**_____

Last Pap smear: When _____ Where_____ Result_____

Have you had an Abnormal Pap smear? _____. How were you treated? _____ _____

Last Mammogram: When_____ Where_____ Result_____

Have you had any STD's____. If yes Name_____Diagnosed Date_____Treated date_____

Domestic Violence: Have you ever been hit, slapped, and kicked by anyone you know? _____

Tobacco: Do you smoke or chew Tobacco? _____ If yes How many cigarettes a day? ____ How often_____

Alcohol: Do you drink? _____ ? **Do you Use Illicit Drugs**? _____ if yes when was the last time used? _____

Pregnancy History: Number of times pregnant___ Full term___ Premature Births_____ Miscarriages__

Abortions___ Living___ Age at the time of 1st pregnancy____ Any complications_____

We will ask you for Family/ Medical/ Surgical history. Some of the questions might seem repetitive. Please be patient. If you do not want to answer any of the questions please say I do not want to answer that question and we will skip to the next. All the questions are necessary to have an accurate history. Thank you in advance for understanding.

PATIENT NAME_____ Signature _____

Date of signature_____ Date of Birth_____