RiverBend
MEDICAL GROUP
Department of Obstetrics and Gynecology

OB-GYN HISTORY FORM

Name: _____ Date: _____

Age: _____ **Primary Care Physician:** _____

MENSTRUAL HISTORY:
Age periods began: _____ Number of days from beginning of period to start of next period: _____
Number of days period lasts: _____ The flow is: LIGHT MODERATE HEAVY (underline)

PREGNANCY HISTORY: Number of pregnancies: _____
Number of: 1. Full term deliveries _____ 2. Premature deliveries _____ 3. Miscarriages _____
4. Abortions _____ 5. Tubal pregnancies _____ 6. Living children _____
Ages of children: _____

Please check any disorder that affects or has affected you or an immediate family member (mother, father, brother, sister or your children.)

	Self	Family		Self	Family
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression / Anxiety		
Venereal Disease (STD)			Mental Illness		
Heart trouble / murmur			Anemia / Blood transfusions		
Diabetes			Seizures / Epilepsy		
High Blood pressure			Bowel problems		
Stroke			Glaucoma		
Thyroid Disease			Joint problems		
Kidney Disease			Liver Disease / Hepatitis		
Other:			Other:		
Other:			Other:		

Please check all surgeries you have had.

Tonsillectomy	Appendectomy
Cesarean section Number:	Heart surgery
Bowel surgery	Urinary / Kidney surgery
Joint surgery	Tubal Ligation
Hysterectomy Reason:	Removal of Gallbladder
Ovary surgery	Infertility surgery
Eye surgery	Hernia repair
Other:	Other:

Please list your current medications and their dose.

Drug	Dose	Drug	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Allergies: _____

Please check all that apply:

____ Do you use any form of birth control? Method: _____ Vasectomy? ____
____ Do you smoke cigarettes? Packs per day ____ Years ____
____ Do you drink alcohol? Drinks per day ____ Drinks per week ____
____ Do you use recreational drugs? Which ones? _____
____ Do you drink more than 3 cups of coffee or tea per day?
____ Are you having family problems?
____ Does anyone with whom you live have a significant medical problem?
____ Do you feel unsafe at home?

School completed: Please circle: High School College Graduate Degree Other

Current or most recent occupation: _____
Are you happy with your work? Please circle: YES NO

Signature of patient: _____

Provider Notes:

Annual Review of History

Date reviewed: _____ Physician Signature: _____
Date reviewed: _____ Physician Signature: _____
Date reviewed: _____ Physician Signature: _____
Date reviewed: _____ Physician Signature: _____
Date reviewed: _____ Physician Signature: _____