Oregon Medical Group

OB/GYN Medical History Questionnaire

Name:_____ Date of Birth:_____ Today's Date:_____

Reason for seeking medical attention:_____

I was referred to this office by:_____

Other doctors involved in my care:_____

Personal Medical History: Have you ever experienced, or been diagnosed with the following (please circle):

Heart Disease:
Murmur
Angina
Heart failure
Bypass surgery
Valve replacement
Heart infection
Irregular heartbeat
Heart attack

Infectious Disease:
AIDS or HIV
Tuberculosis
Genital warts
Herpes
Chlamydia
Gonorrhea
Trichomonas

Lung Disease:
Emphysema/COPD
Asthma
Pneumonia
Sleep Apnea

Musculoskeletal:
Arthritis
Gout
Joint pain

Gynecological:
Abnormal pap
(date)_____
Endometriosis
Fibroids
Cysts
Irregular bleeding
DES Exposure

Gastrointestinal:
Ulcers
Abnormal Colonoscopy
Gallstones
Hiatal hernia
Hepatitis, type ___
Hemorrhoids
Irritable bowel syndrome
Colitis
Diverticulitis
GI Bleeding
Kidney/Bladder:
Stones
Renal/Kidney failure
Urinary incontinence
Infection

General:
High blood pressure
Diabetes
High cholesterol
Migraines/headaches
Anemia
Thyroid problem
Blood clot
Stroke
Seizure disorder
Paralysis
Bleeding disorder
Glaucoma
Cancer
(type)_____
_____
Anxiety
Depression
Mental illness

Eating disorder
Alcoholism
Drug abuse
Allergies/hayfever
Blood transfusion

Medical/Surgical History:

	Date	Surgical Procedure		Date	Surgical Procedure
1.			4.		
2.			5.		
3.			6.		

Current Medications: (include birth control pills and non-prescription items such as vitamins, aspirin, herbs, etc.)

	Name	Dose	Times/Day		Name	Dose	Times/Day
1.				4.			
2.				5.			
3.				6.			

Allergies (include drugs, food, substances, animals, etc.):

	Allergy to:	Reaction:		Allergy to:	Reaction:
1.			4.		
2.			5.		
3.			6.		

Social History:

Occupation:_____

Current Marital Status: S M W D

Do you feel safe in your home? Yes No

Living Situation: Alone Roommate Spouse Parents Significant Other With Children

Do you wear a seat belt? Yes No

Do you have sex with: Man Woman Both

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Patient Name:_____ **DOB:**_____

Preventative Health Status:

Do you exercise regularly? Yes No Type:_____ How often:_____

Do you use tobacco/e cigarettes Yes No How much/how long?_____ Quit? When:_____

Do you drink alcohol? Yes No How much per day?_____ Quit? When:_____

Have you used illicit drugs? Yes No Which ones?_____ Quit? When:_____

Last flu and or DTap immunization (please give dates if known):_____

Have you ever had a blood transfusion? Yes No When:_____

Major injuries/date:_____

_____

GYN History:

Date of last period:_____ Age periods began:_____ Date of last pap:_____

History of abnormal pap? Yes No Date of last mammogram:_____

Current Birth Control Method:_____ Age at start of menopause:_____

OB History:

Total number of pregnancies:_____ Problems during pregnancy:_____

Total number of live births:_____

Number of vaginal deliveries:_____ Number of living children:_____

Number of c-section deliveries:_____ Number of miscarriages/Abortions:_____

Family History:	Age if living	Age when deceased	Illness/cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____

Immediate Family History (circle all that apply) Parents, Grandparents, Aunts/Uncles, Siblings

Diabetes Heart Disease Bleeding Disorder Stroke Thyroid Disease Hypertension Mental Illness Blood Clots

Cancer: Breast Uterine Cervical Ovarian Colon Other:_____

Other significant family history information:_____

_____

Physician Signature_____ **Today's Date**:_____