Sierra Women's Health

OB / GYN HISTORY FORM

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Name	Date of Birth	Age	Date

Ethnicity: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other

Past Obstetrical History - To include miscarriages, ectopics and abortions.

Date (Mo. /Yr.)	Birth Weight	Gender	Type of delivery (Vaginal/c-sec.)	Place of delivery	Complications

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Age at 1st period	Contraception
Last menstrual period	Age at Menopause History of IUD use ☐ Yes ☐ No
Duration of flow	Bone Density ☐ Yes - when_____, ☐ No
Cramps? Mild / Mod / Severe / None	Colonoscopy ☐ Yes - when_____, ☐ No
Time between periods	Osteopenia ☐ Yes ☐ No Osteoporosis ☐ Yes ☐ No

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ HIV ☐ Trichomonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Other

Patient Pharmacy _____

Allergies - List Reaction	**Medications & Dosage** - Include Vitamins / Herbs