sacramento women's health
an ob/gyn partnership

Patient History

Name _____ Date: _____

Marital/Partner Status: _____ How Long _____ Age: _____

How did you hear about our office? _____

Please answer the following questions that are pertinent to you to the best of your ability.

What is the main reason for your visit? _____

_____

Other issues you would like to address:

1. _____
2. _____
3. _____

Medical History

Do you have any allergies to medications? (Please list) _____

_____

Current Medications:

_____

_____

_____

Do you have or have you had any medical problems? (Please list)

Yes No

- ☐ ☐ Lung disorders including asthma: _____
- ☐ ☐ Heart disease or high blood pressure: _____
- ☐ ☐ Urinary tract disorders: _____
- ☐ ☐ Gastrointestinal disorders: _____
- ☐ ☐ Gynecological disorders: _____
- ☐ ☐ Endocrine disorders (diabetes, thyroid): _____
- ☐ ☐ Infectious diseases: _____
- ☐ ☐ Cancer: _____
- ☐ ☐ Psychiatric or neurological disorders: _____
- ☐ ☐ Other: _____

When was your last Pap smear test? _____

Have you ever had an abnormal Pap smear or HPV test? _____

Your last Mammogram? _____

Please list all surgeries with the approximate date: _____

_____

_____

_____

Please list any other hospitalizations with the reason and date: _____

_____

_____

_____

Social and Dietary History

Do you smoke? _____ If yes: number of cigarettes per day _____ Number of years_____

Do you drink alcohol? _____ If yes approximate number of glasses per week_____

Caffeine? ____ Cups per day ____ Do you use any illicit drugs or have you had any addictions in the past?_____

Are you currently in an abusive situation or have you been in one in the past?_____

Is your weight stable? _____ Do you follow a particular diet?_____

Do you take any vitamins or calcium?_____ Have you ever had an eating disorder? _____

Do you exercise regularly? _____ Have you had all your vaccinations? _____

Do you do monthly self-breast exams? If no, why? _____

Menstrual and Pregnancy History *(Use back of page if necessary)*

Menstrual

Date of last menstrual period _____ Age at first period_____

Are your periods regular? _____ How many days apart? _____

Do you take pain medications for cramps?_____ If so, what do you take?_____

Do you have hot flashes or night sweats? _____ If so how often? _____

Have you ever taken hormone medication? (List the medication and doses) _____

_____

Pregnancy

How many pregnancies? _____ Number of vaginal deliveries _____

Number of cesarean sections_____ Number of miscarriages_____

Number of abortions _____

Are you currently trying to get pregnant?_____ If so, how long have you tried?_____

Have you ever had an infertility evaluation?_____ If so, when and what was done?_____

What form of birth control do you use now? _____

What types if any have you tried in the past? Complications?_____

_____

Are you sexually active? _____

Any possible exposures to a sexually transmitted disease? _____

Would you like to be tested for a sexually transmitted disease? _____

Family History

Please check any diseases that a member of your family has been affected by, and list which members were affected and their age at diagnosis.

☐ Hypertension _____

☐ Lupus_____

☐ Arthritis _____

☐ Diabetes _____

☐ Intestinal Disease _____

☐ Cancer (please indicate type) _____

☐ Osteoporosis _____

☐ Heart Disease _____

☐ Alzheimer's _____

☐ Parkinson's Disease _____

☐ Birth Defects _____

☐ Genetic Disorders _____