Chester County Ob | Gyn Associates

*Affiliated with The Health Network of The Chester County Hospital*

Name: _____ D.O.B.: _____

Address: _____ Phone (Home): _____

_____ Phone (Work): _____

In order for us to provide quality care to you, we ask that you fill in the answers to the questions below. All answers will be kept confidential. We'd like you to feel comfortable about discussing any questions or concerns you have with your doctor or nurse.

**Reason for your visit?**

**Allergies (Medicine, food, other)** **Reactions? (Rash, itching, swelling?)**

**Medications (List all medicines that you take, how much and how often)**

| | |
|---|---|
| | |
| | |
| | |

| **GYN HISTORY:** | | **COMMENTS** |
|---|---|---|
| Date of last Period: | ___/___/___ | Interval between periods _____ |
| Age when Periods began: | ____Yrs. old | |
| Do you have loss of urine? | ☐ No | ☐ Yes |
| Do you have any urinary problems? | ☐ No | ☐ Yes |
| Any history of abnormal PAP smears? | ☐ No | ☐ Yes If "Yes", any treatment? Yes No |
| Any prolonged abnormal bleeding? | ☐ No | ☐ Yes |
| Any pelvic pain? | ☐ No | ☐ Yes If "Yes", any treatment? Yes No |
| Any abnormal discharge? | ☐ No | ☐ Yes |
| Do you have symptoms of Menopause? | ☐ No | ☐ Yes |
| Do you take hormonal replacement? | ☐ No | ☐ Yes |
| Do you do self-breast exams monthly? | ☐ Yes | ☐ No |
| Do you take calcium supplements? | ☐ Yes | ☐ No |

| **SEXUAL HISTORY** | | |
|---|---|---|
| Are you sexually active? ☐ Yes ☐ No | Heterosexual ☐ Yes ☐ No | Homosexual ☐ Yes ☐ No Bisexual ☐ Yes ☐ No |
| Have you had multiple sexual partners? | ☐ No | ☐ Yes How Many?_____ |
| Do you use condoms? | ☐ Yes | ☐ No |
| What method of birth control do you use? | (_____) | ☐ None |
| Have you ever been treated for a sexually transmitted disease? | ☐ No | ☐ gonorrhea ☐ herpes ☐ chlamydia ☐ HPV ☐ syphilis ☐ hepatitis ☐ OTHER |
| Have you ever been tested for HIV/AIDS? | ☐ No | ☐ Yes |
| Do you wish to be tested for any sexually transmitted disease? | ☐ No | ☐ Yes |

| **WHEN WAS THE LAST TIME YOU HAD ANY OF THE FOLLOWING: (give approximate date)** | | |
|---|---|---|
| PAP smear? | ___/___/___ | Where? |
| Breast exam? | ___/___/___ | |
| Mammogram? | ___/___/___ | Where? |
| Sigmoid/colon exam? | ___/___/___ | Where? |
| Stool check for blood? | ___/___/___ | |
| Complete Physical? | ___/___/___ | Where? |

**OB HISTORY**

| Delivery Date | Vaginal/C-Section | Baby's Sex & weight | Birth Place | Complications | Current Health of Children |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Number of miscarriages: _____ Number of abortions: _____

( 4/05 )

PLEASE TURN AND COMPLETE OTHER SIDE

| LIST ALL SURGERIES AND APPROXIMATE DATES: | |
|---|---|
| | __/__/__ |
| | __/__/__ |
| | __/__/__ |
| | __/__/__ |
| | __/__/__ |
| **LIST ALL REASONS FOR HOSPITALIZATIONS AND APPROXIMATE DATES:** | |
| | __/__/__ |
| | __/__/__ |
| | __/__/__ |

**Please check if you have ever had any of the following:**

| | | | | |
|---|---|---|---|---|
| ☐ High Blood Pressure | ☐ Breathing Problems | ☐ Blood Disorders | ☐ Alcohol Abuse | ☐ Phlebitis |
| ☐ Diabetes | ☐ Thyroid Problems | ☐ Blood Transfusions | ☐ Drug Abuse | ☐ Migraine Headaches |
| ☐ Cancer (Gyn, Breast, Colon, Other _____ ) | ☐ Heart Problems | ☐ Osteoporosis | ☐ Liver Disease | ☐ Other_____ |
| | ☐ Breast Problems | ☐ Depression | ☐ Kidney Problems | |

**Has anyone in your family had any of the following:**

| | | | |
|---|---|---|---|
| ☐ Cancer (Gyn, Breast, Colon, Other _____ ) | Who?_____ | ☐ Thyroid Disease | Who?_____ |
| ☐ Osteoporosis | Who?_____ | ☐ Seizures | Who?_____ |
| ☐ High Blood Pressure | Who?_____ | ☐ Genetic Disease (_____) | Who?_____ |
| ☐ Heart Disease | Who?_____ | ☐ Bleeding Disorder | Who?_____ |
| ☐ Diabetes | Who?_____ | ☐ Autoimmune Disorder | Who?_____ |
| Is your mother alive? ☐ Yes ☐ No (Age at Death ____ ) | | Is your father alive? ☐ Yes ☐ No (Age at Death ____ ) | |

## SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Present Occupation? _____

Have you worked with chemicals, paints, asbestos, leads or other hazardous materials? No ☐ Yes ☐

How many people live with you now?

Do you feel threatened by your current relationship? No ☐ Yes ☐

Have you ever been physically or emotionally abused No ☐ Yes ☐

## PERSONAL HABITS

| | | | |
|---|---|---|---|
| Do you use tobacco products? | No ☐ Yes ☐ | If "Yes" how often? | _____ packs per _____ |
| Do you drink alcohol? | No ☐ Yes ☐ | If "Yes" ⇨ | What Kind?_____<br>How Much?_____ |
| Do you use drugs | No ☐ Yes ☐ | If "Yes" ⇨ | What Kind?_____<br>How Often?_____ |
| Do you exercise regularly? | Yes ☐ No ☐ | If "Yes" ⇨ | What Type?_____<br>How Often?_____ |
| Do you have a "Living Will"? | Yes ☐ No ☐ | Are you an organ donor? | Yes ☐ No ☐ |

Patient Signature: _____ Date:_____

Reviewed By: _____ Date: _____