Cheyenne OB GYN
Generations of Excellence. Caring for Women.

Health History Form

Date: ______________________

Name: ____ DOB: ______________________

Reason for Visit Today: ____

Medical History: Do you have any health problems? (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder or Kidney Problems
- ☐ Blood Clots
- ☐ History of Blood Transfusion
- ☐ Breast Problems
- ☐ Depression
- ☐ Stomach/Bowel Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Problems
- ☐ Migraine Headaches
- ☐ Neurologic Problems
- ☐ Polycystic Ovarian Syndrome
- ☐ Seasonal Allergies
- ☐ Serious Injuries
- ☐ Thyroid Problems
- ☐ Stomach Ulcers
- ☐ Other: ______________________
- ☐ Other: ______________________
- ☐ Other: ______________________
- ☐ Other: ______________________

Please explain any checked boxes: ____

____

Past Surgical History

Date of Surgery	Type of Surgery	Complications

Medications (List all current medications including over the counter meds.)

Medication	Dose

Allergies

Medication	Reaction

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Kindness. Compassion. Experience you can trust.

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Date: ____________________

Name: ____________________

Family Medical History

Has anyone in your family had these medical conditions? Who and what relation to you?

- ☐ Diabetes
- ☐ Stroke/Blood Clot
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Thyroid Problems
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Uterine Cancer
- ☐ Colon Cancer

Other: ____________________

Are there any genetic or inherited health problems in your family? If so, what was it and how were they related to you? ____________________

Gynecological History

Age at first period: ____________________ Regular periods? ☐ Yes ☐ No

How many days from the start of the period to the start of the next period? ____________________

How long does your period last? ____________________ Is it: ☐ Light ☐ Moderate ☐ Heavy

Are your periods painful? ☐ No ☐ Yes, explain: ____________________

When was the first day of your last menstrual period? ____________________

Are you certain of this date? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

What are you using for contraception? ____________________

Are you having symptoms of menopause? ☐ No ☐ Yes, explain: ____________________

At what age did you stop having periods? ____________________ years old

Are you using hormones? ☐ No ☐ Yes, explain: ____________________

Pap Smear History

When was your last pap? ____________________ What it normal? ☐ Yes ☐ No

Have you ever had an abnormal pap? ☐ No ☐ Yes, when? ____________________

What was wrong with it? ____________________

How was it treated? ____________________

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Health History Form

Date: ____________

Name: ______________________________ DOB: ____________

Pregnancy History: Number of Pregnancies (including miscarriages and abortions): ______

Number of Babies: Term: ______ Preterm: ______ Miscarriages: ______

Date of Birth	Gestational Age	Hours in Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Early Labor?

Any complication with any pregnancy? ☐ No ☐ Yes, explain ______________________

____

____

Social History

Do you smoke? ☐ No ☐ Yes, how much? ____________ Years since started? ______

Do you drink? ☐ No ☐ Yes, how much and how often? ______________________

Do you use recreational drugs? ☐ No ☐ Yes, what and how much? ______________________

What is your highest level of education? ☐ Grade School ☐ High School ☐ College ☐ Other

Are you working now? ☐ No ☐ Yes, what is your job? ______________________

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____________

Onset of sexual activity before 16 years of age? ☐ No ☐ Yes

Five or more sexual partners in your lifetime? ☐ No ☐ Yes

History of sexually transmitted disease? ☐ No ☐ Yes, what? ______________________

History of sexual abuse? ☐ No ☐ Yes

Have you had a mammogram? ☐ No ☐ Yes, when? ____________ Result: ____________

Have you had a colonoscopy? ☐ No ☐ Yes, when? ____________ Result: ____________

Have you had a DEXA scan? ☐ No ☐ Yes, when? ____________ Result: ____________
(Bone Density)