WESTERN
Gynecological + Obstetrical Clinic
Total Women's Health Care

Western Gyn/Ob
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REQUEST FOR MEDICAL HISTORY

Name of Patient:	DOB:
Primary Care Doctor:	Date:

What are you allergic to?
What medical problems do you have (asthma, diabetes, depression, thyroid, etc.)?
What surgeries have you had in the past (include years)?
List medical problems that run in your family (heart disease, cancer, diabetes, etc.):
What medicines do you take (dose & how often)?

PREGNANCY HISTORY

Number of pregnancies:	_____	☐	Preeclampsia/Eclampsia/Toxemia
Number of miscarriages/abortions:	_____	☐	High blood pressure
Number of term deliveries:	_____	☐	Postpartum depression
Number of preterm deliveries:	_____	☐	Diabetes
Number of living children:	_____	☐	Other:
Number of C-sections:	_____		
Pregnancy complications?	_____		

GYNECOLOGIC HISTORY

Age you had your first period?	_____	Age at menopause?	_____
How often do you get a period?	_____	What do you use for birth control?	
How many days does it last?	_____	_____	

Do you have irregular cycles?	☐ YES	☐ NO	☐ N/A
Do you have painful periods?	☐ YES	☐ NO	☐ N/A
Do you have heavy periods?	☐ YES	☐ NO	☐ N/A
Do you have pain with sex?	☐ YES	☐ NO	☐ N/A
Do you have PMS?	☐ YES	☐ NO	☐ N/A
Do you have vaginal discharge?	☐ YES	☐ NO	☐ N/A

Do you have spotting between periods?	☐ YES	☐ NO
Do you have hot flashes?	☐ YES	☐ NO
Have you ever had an abnormal pap smear?	☐ YES	☐ NO
Have you ever had a Cone Biopsy or LEEP?	☐ YES	☐ NO
Have you ever had herpes?	☐ YES	☐ NO
Have you ever had chlamydia or gonorrhea?	☐ YES	☐ NO
Have you ever had any other STDs?	☐ YES	☐ NO

SEXUAL HEALTH

What is your sexual orientation?	☐ Straight	☐ Gay/Lesbian	☐ Bisexual	☐ Other
Are you sexually active?	☐ YES	☐ NO		
Do you have problems with sex (pain, arousal, dryness)?	☐ YES	☐ NO	☐ N/A	
How many sexual partners have you had? _____				

PREVENTATIVE HEALTH

Do you exercise?	☐ YES	☐ NO	
Do you eat from all food groups?	☐ YES	☐ NO	
Do you wear sunscreen?	☐ YES	☐ NO	
Do you wear a seatbelt?	☐ YES	☐ NO	
Do you go to the dentist every 6 months?	☐ YES	☐ NO	
Do you get eye exams every year?	☐ YES	☐ NO	
Do you wear a helmet during sports?	☐ YES	☐ NO	
Do you feel safe in your home?	☐ YES	☐ NO	
Do you drink alcohol?	☐ YES	☐ NO	☐ In the past
Do you smoke cigarettes?	☐ YES	☐ NO	☐ In the past
Do you use drugs?	☐ YES	☐ NO	☐ In the past

SCREENING

When was your last pap smear? _____	☐ NORMAL	☐ ABNORMAL	☐ N/A	
When was your last mammogram? _____	☐ NORMAL	☐ ABNORMAL	☐ N/A	
When was your last colonoscopy? _____	☐ NORMAL	☐ ABNORMAL	☐ N/A	
When was your last DEXA/bone scan? _____	☐ NORMAL	☐ ABNORMAL	☐ N/A	
Cholesterol, diabetes, & thyroid screening? _____	☐ NORMAL	☐ ABNORMAL	☐ N/A	

VACCINATIONS

Have you ever had the MMR shot?	☐ YES, YEAR: _____	☐ NO
Chicken Pox or varicella shot?	☐ YES, YEAR: _____	☐ NO
TDAP or tetanus shot?	☐ YES, YEAR: _____	☐ NO
Gardasil of HPV shot?	☐ YES, YEAR: _____	☐ NO
Hepatitis A & B shot?	☐ YES, YEAR: _____	☐ NO
Pneumovax of pneumonia shot?	☐ YES, YEAR: _____	☐ NO
Zoster or shingles shot?	☐ YES, YEAR: _____	☐ NO

REVIEW OF SYSTEMS
(circle all that apply to you):

CARDIOVASCULAR:
Chest pain
Leg swelling
Heart valve problems
Heart murmur
Heart Palpitations
Carotid artery disease
Aorta problems
Other _____

CONSTITUTIONAL:
Change in weight
Decreased appetite
Fevers
Chills
Night sweats
Fatigue
Bloating
Other _____

ENDOCRINE:
Thyroid problems
Diabetes
Extreme thirst
Nipple discharge
Other _____

GASTROINTESTINAL:
Indigestion/heartburn
Hard time swallowing
Ulcers
Gallbladder trouble
Nausea/vomiting
Vomiting blood
Constipation
Diarrhea
Liver disease
Hemorrhoids
Blood in stools
Hepatitis
Jaundice (yellow skin)
Other _____

GENITOURINARY:
Bladder/kidney
Infections
Urinary urgency
Urinary frequency
Leaky bladder
Burning
Bloody urine
Other _____

HEENT:
Change in vision
Glasses/contacts
Change in hearing
Dental issues
Swollen nodes
Other _____

HEMATOLOGIC:
Anemia
Past blood transfusion
Blood clots legs/lungs
Hemophilia
Sickle cell
Leukemia/lymphoma
Other _____

MUSCULOSKELETAL:
Broken bones
Muscle pain
Joint pain
Arthritis
Other _____

NEUROLOGIC:
Seizures
Headaches
Migraines
Migraines with aura
Numbness
Tingling
Weakness
Other _____

PULMONARY:
Hard time breathing
Cough
Sputum
Pneumonia
Bronchitis
Asthma
Wheezing
Other _____

SKIN:
Abnormal hair growth
Acne
Rashes
Other _____