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? _____				

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	☐ NO
Chicken Pox or varicella shot?	☐ YES	☐ NO
TDAP or tetanus shot?	☐ YES	☐ NO
Gardasil of HPV shot?	☐ YES	☐ NO
Hepatitis A & B shot?	☐ YES	☐ NO
Pneumovax of pneumonia shot?	☐ YES	☐ NO
Zoster or shingles shot?	☐ YES	☐ NO