DELAWARE VALLEY OBGYN AND INFERTILITY GROUP, PC
PATIENT HISTORY FORM (PAGE 1 OF 2)

Name: ________________________Date of Birth: ________________ Today's Date:__________
Primary Care Physician: ________________________________Phone: ____________________

Family History Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative/Age at Diagnosis
☐ Breast Cancer		☐ Diabetes	
☐ Colon Cancer		☐ High Blood Pressure	
☐ Ovarian Cancer		☐ Heart Disease	
☐ Uterine Cancer		☐ Other	

Medical History Have you ever had any of the following?

□ Anemia **□ Arthritis** **□ Asthma** **□ Bladder Infections**
□ Bleeding Problems **□ Blood Clots Legs/Lungs** **□ Blood Transfusion** **□ Cancer**
□ Chicken Pox **□ Depression/Anxiety** **□ Diabetes** **□ Drug /Alcohol Problem**
□ Epilepsy/Seizures **□ Gall Bladder Disease** **□ Genetic Condition** **□ GERD/reflux**
□ Heart Disease/Attack **□ High Blood Pressure** **□ High Cholesterol** **□ Kidney Infections**
□ Liver Disease/Hepatitis **□ Migraines** **□ Mitral Valve Prolapse** **□ Pelvic Infections**
□ Pneumonia **□ Sickle Cell Disease** **□ Stroke** **□ Thyroid Problem**
□ Tuberculosis **□ Other** ____

Social History

Alcohol Use **□ Yes □ No If yes, _______ drink(s) / day/week/month for _____ years. □ Quit drinking**
Tobacco Use **□ Yes □ No If yes, _______ pack(s) per day for _____ years. □ Quit smoking**
Street Drug Use **□ Yes □ No Type and frequency** ____
Exercise **□ Yes □ No Type and frequency** ____
Caffeine **□ Yes □ No If yes, ________ caffeinated drinks (coffee, tea, soda) per day/week**
Emotional Abuse **□ Yes □ No If yes, are you safe now? □Yes □No Counseling? □Yes □No**
Physical Abuse **□ Yes □ No If yes, are you safe now? □Yes □No Counseling? □Yes □No**
Sexual Abuse **□ Yes □ No If yes, are you safe now? □Yes □No Counseling? □Yes □No**

Surgical History Please list all surgeries with dates:

____ ____
____ ____
____ ____

List all medications you are currently taking, including over-the counter medications, vitamins and herbal remedies:

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

List any allergies to medications:

______________________________ ______________________________ ______________________________

□ No Known Drug Allergies

Have you had the Gardasil vaccine (3 injections)? **□ Yes □ No**
Have you had a Tetanus booster in the past 2 years? **□ Yes □ No**

DELAWARE VALLEY OBGYN AND INFERTILITY GROUP, PC
PATIENT HISTORY FORM (PAGE 2 OF 2)

Name: ____

Obstetrical History

□ Never been pregnant □ Adopted children (please list name, age and sex)
Please list all pregnancies in order including miscarriage, premature births, stillbirths, ectopics (tubal) and abortions:

			Type of	Length of		
Year	M/F	Weight	Delivery	Pregnancy	Problems	Name/Age

Gyn History

Age of first period ___________ Periods are: □ Regular Flow is: □ Light
Age of last period ___________ □ Irregular □ Light to moderate
Cycle length: every _______ days □ Painful □ Moderate to heavy
lasting _______ days □ Not really bothersome □ Very heavy
Are you sexually active? □ Yes □ No Do you have sex with: □ Men □ Women New partners in the past year? □ Yes □ No
Any concerns about sexual activity you want to discuss with your provider? □ Yes □ No
Method of birth control: □ condoms □ IUD □ natural family planning □ none
□ partner with vasectomy □ patch □ pills
□ vaginal ring □ tubal/Essure □ other ___________________________
Have you ever had any of the following STDs? □ Chlamydia □ Gonorrhea □ Hepatitis B □ Never had any
□ Hepatitis C □ Herpes □ HIV
□ HPV □ Syphilis □ Trichomonas
Have you ever had any of the following? □ Endometriosis □ Fibrocystic breasts □ Fibroids
□ Ovarian cysts □ Uterine abnormalities
Date of last pap smear? _______________ □ Normal □ Abnormal
Have you ever had any of the following? □ Endometriosis □ Fibrocystic breasts □ Fibroids
□ Ovarian cysts □ Uterine abnormalities
Have you ever needed any of the following or an abnormal pap? □ Coloposcopy □ LEEP/Laser/Conization
□ Cryosurgery □ No
Date of last mammogram? _______________ □ Normal □ Abnormal □ Never had one
Date of bone density? _______________ □ Normal □ Osteopenia □ Osteoporosis □ Never had one
Date of last mammogram? _______________ □ Normal □ Abnormal □ Never had one

Review of Systems

Have you ever had any of the following?

□ Generally healthy □ Back pain □ Bladder infection □ Blood in stools □ Breast lumps
□ Burning with urination □ Chest pain □ Chronic cough □ Constipation □ Depression/anxiety
□ Diarrhea □ Fever □ Frequent urination □ Hearing loss □ Heartburn/reflux
□ Incontinence □ Irregular vaginal bleeding □ Joint/muscle pain □ Painful intercourse
□ Pelvic pain □ Recent weight gain >25 lbs □ Shortness of breath □ Sinus problems
□ Stomach pains □ Urgency □ Vaginal discharge □ Varicose veins □ Vision problems
□ None □ Other ____

Patient Signature: ____________________________________ Date: _______________________

Clinician Signature: ____________________________________ Date: _______________________