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:

Year	M/F	Weight	Type of Delivery	Length of 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 Do you have sex with: ☐ Men New partners in the past year? ☐ Yes ☐ No
☐ No ☐ Women
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
☐ Hepatitis C ☐ Herpes ☐ HIV had any
☐ 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 colonoscopy? _____ ☐ 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: _____