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 & INFERTILITY GROUP

DELAWARE VALLEY OBGYN AND INFERTILITY GROUP, PC

PATIENT HISTORY FORM (PAGE 2 OF 2)

Name: ____

Date of Birth: _______________

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 __________

Age of last period __________

Cycle length: every ______ days, lasting ______ days

Periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ Not really bothersome

Flow is: ☐ Light ☐ Light to moderate ☐ Moderate to heavy ☐ 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 ☐ partner with vasectomy ☐ vaginal ring ☐ IUD ☐ patch ☐ tubal/Essure ☐ natural family planning ☐ pills ☐ other ______________________ ☐ none

Have you ever had any of the following STDs? ☐ Chlamydia ☐ Hepatitis C ☐ HPV ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ Hepatitis B ☐ HIV ☐ Trichomonas ☐ Never had any

Have you ever had any of the following? ☐ Endometriosis ☐ Ovarian cysts ☐ Fibrocystic breasts ☐ Uterine abnormalities ☐ Fibroids

Date of last pap smear? _____________ ☐ Normal ☐ Abnormal

Have you ever had any of the following? ☐ Endometriosis ☐ Ovarian cysts ☐ Fibrocystic breasts ☐ Uterine abnormalities ☐ Fibroids

Have you ever needed any of the following or an abnormal pap? ☐ Coloposcopy ☐ Cryosurgery ☐ LEEP/Laser/Conization ☐ 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: ___________________