GREATER BADEN
MEDICAL SERVICES
Primary and Preventive Health Care

OB/GYN Health History
Intake Part 1

Today's Date:________________

What is the reason for your visit today? Please provide reason(s) and brief description below:

Problem	Description (Date problem started)

In the past or currently have you been diagnosed with a chronic medical condition(s)? Yes or No If yes, please list them below:

Please list all medications you are currently using below: Include any over the counter or herbal medications:

Medications Name	Dosage	How often do you take it?

Please list all food and medication allergies:

Food or Medications	Reaction- brief description

Please list any health care provider you are seeing and any pharmacies you use:

Name	Specialty/	Address	Phone	Fax

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OB/GYN Health History
Intake Part 2

Today's Date ____________

Have you had any surgeries? No If Yes, please list dates and provide details:

Date	Diagnosis, Type of surgery performed and Details

Please list all vaccinations/immunizations you have had below:

Immunizations	Date of Immunization (Most Recent)
Tetanus/Diphtheria	
Pneumococcal	
Hepatitis B	
Hepatitis A	
MMR	
Varicella	
Meningococcal	
Influenza	
HPV (Gardasil)	
Others	

Please list any illness or diseases of your immediate family member below:

Relationship	Illness/Diseases	Age of Onset	Date of Death	Comments

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OB/GYN Health History Intake Part 3 Today's Date_______________

Please complete your past medical history:

Illness or Symptoms	Self (Chec k)	Age of Onset	Comments List Provider's name if under medical care
Alcoholism			
Allergies or Hay Fever/			
Anemia (including Sickle Cell Anemia			
Arthritis or Gout			
Asthma			
Bleeding or Clotting Disorder			
Blood Transfusion			
Cancer - Type			
COPD			
Diabetes			
Glaucoma			
Headache including Migraine			
Heart Attack or Coronary Artery Disease			
Heart Murmur			
Heartburn or Reflux (GERD)			
Hepatitis or Jaundice			
High Blood Pressure			
HIV/AIDS			
Intestinal Bleeding			
Malaria			
Mental Illness/ Depression			
Obstructive Sleep Apnea			
Peptic Ulcer			
Seizures			
Skin Problems			
Stroke			
Thyroid Disease			
Tuberculosis			
Other Illness			
None of the above			

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OB/GYN Health History Intake Part 4 Today's Date___________

Please complete lifestyle and social history below:

Marital Status (please circle): Married l Single l Divorced l Separated l Widowed l Domestic Partner
Occupation:___________________ Education (highest grade or other training):____________
Living situation (housing):_________________________
If you are pregnant did you drink alcohol prior to pregnancy? ☐ Yes or ☐ No
Do you currently drink alcohol? ☐ Yes or ☐ No How many drinks per week?___ ☐ Age of first usage: Do currently smoke? ☐ Yes or ☐ No If you are pregnant, did you smoke prior to pregnancy? ☐ Yes or ☐ No
How many per day?___________ Since (age)________
If you are an ex-smoker, how long did you smoke? How many per day___, and when did you quit?__
Does anyone else in the home smoke? ☐ Yes or ☐ No
Do you currently or have you ever used recreational drugs? ☐ Yes or ☐ No
How often?_________ If so, list:____________________________Date of last usage:__________
Now or in the pass have you ever been abused, such as rape, physical abuse, domestic violence? ☐ Yes or ☐ No If yes, who was/is the abuser?________________________
Do you feel safe in your relationship? ☐ Yes or ☐ No
Is a blood transfusion acceptable in an emergency? ☐ Yes or ☐ No
Do you exercise?____If yes, what type?______How long?______How often?_____Current weight:___
Disability, if any____

Please complete your GYN history below:

Date of your last menstrual period:______Is this date (please circle): approximate l definite Was your last menstrual period normal amount and duration? ☐ Yes or ☐ No
Age of first menstrual cycle:__Does your menstrual cycle come every month? ☐ Yes or ☐ No Menses flow (please circle): Light l Moderate l Heavy Pain with menses? ☐ Yes or ☐ No
Are you sexually active? ☐ Yes or ☐ No Do you have sex with (please circle): Men l Women l Both ☐ Are you pregnant? ☐ Yes or No
Current birth control method:__________Past birth control method(s):_________________________
Have you ever had a sexually transmitted illness in the past? Yes or No If yes, what?___________
Do you have any sexual problems or concerns? ☐ Yes or ☐ No

Please complete you OB history below:

Total number of pregnancies:Of these pregnancies how many were:
Full Term:____Premature:____Abortion:____Miscarriage:____Ectopic:____Multiple Birth:_____
Number of living children:____

Past Pregnancies (including miscarriages & abortions)

Date	Number of Weeks	Length of Labor	Birth Weight	Sex M or F	Type of Delive	Anesthesia	Place of Delive	Preterm Labor	Comments