Moscow-Pullman OB/GYN Annual Health History Today's date ______________________

051502

Please take some time to fill out this history. All information is held strictly confidential and is released only with your written permission.

Name ____ **Date of Birth** _____________________

Current Medications: ____

Allergies: ____

Medical History *Do you or have you ever had: (circle yes or no)**:***

High blood pressure	Yes	No	Epilepsy - Seizures	Yes	No
Heart Disease	Yes	No	Psychiatric illness	Yes	No
Heart Murmur	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Thyroid problems	Yes	No
Tuberculosis	Yes	No	Excessive Hair Growth	Yes	No
Asthma	Yes	No	Unexplained Abdominal Pain	Yes	No
Blood Clots	Yes	No	Diabetes	Yes	No
Free bleeding - hemophilia	Yes	No	Hernia	Yes	No
Blood transfusions	Yes	No	Kidney Disease	Yes	No
Hepatitis - Jaundice	Yes	No	Rubella	Yes	No
Cancer	Yes	No	Other _________________________	Yes	No

GYN History (fill in information and/or circle yes or no):

When was your last PAP Smear? Date: _______________

When was your last mammogram? Date: _______________

How often do you examine your breasts? _________

Age at onset of first Period? _________

Are your cycles irregular? Yes No Interval: __________

Is your flow abnormal? Yes No Duration: _______________

Are your cycles painful? Yes No *(circle one):* Mild Moderate Severe

Do you have abnormal bleeding? Yes No Describe: ______________________________________

Have you had an abnormal Pap? Yes No List date & treatment: ____________________________

Have you been exposed to DES? Yes No Unsure

(Your mother took to prevent miscarriage from midforties to midseventies.)

Have you ever had a breast problem? Yes No

Are you using contraception? Yes No List type & complications: ___________________________

Are you sexually active? Yes No More than one partner? _______

Do you have pain with intercourse? Yes No Describe: _____________________________________

Do you have an abnormal discharge? Yes No List any symptoms: ____________________________

Have you ever had a STD? Yes No *(circle)* Chlamydia GC Trich Herpes HIV Hepatitis B HPV

Have you ever had a pelvic infection? Yes No *(circle)* Appendicitis PID Abbcess

Do you have problems with bowels? Yes No *(circle)* Constipation Diarrhea Pain Blood

Have you gone through menopause? Yes No If yes, date: _________

Have you taken hormone replacement? Yes No *(circle)* Estrogen Progesterone Natural

Do you have problems urinating? Yes No *(circle)* Burning Frequent Urgent Leaking During night

Personal Habits (circle yes or no):

Drink alcohol?	Yes	No	If yes, number of drinks per week: __________
Smoke?	Yes	No	If yes, list number of pacs per day _____, for how long: _________
Used drugs?	Yes	No	If yes, list type & date last used: ____________________________
Had an eating disorder?	Yes	No	
Had problems sleeping?	Yes	No	
Exercise?	Yes	No	If yes, list type & frequency: _______________________________
Caffeine?	Yes	No	If yes, number of cups per day: _________

(Over)