Champlain OBSTETRICS & GYNECOLOGY

Experienced, comprehensive & compassionate care that puts you first.

General History Form

Name:_____

DOB:_____ Age:_____ **Today's Date:**_____

Primary Care Physician: _____ **Baby's Name (if postpartum):** _____

Do you have any drug allergies? ***Yes*** ***No*** **(*If yes, list*)**_____

What is the reason for this visit? _____

PAST HEALTH

Have you ever had:

	YES	NO
Heart Disease		
Pneumonia		
Diabetes/Gestational DM		
Stomach Ulcers		
Diverticulitis, Colitis		
Jaundice		
Anemia		
A Blood Transfusion		
Varicose Veins		
Cancer		
Embolism or Blood Clots		
Asthma		
Mental Problems/Depression		
Epilepsy		
German Measles		
Migraine Headaches		
Kidney or Bladder Disease		
Pelvic Diseases or PID		
Herpes		
Gonorrhea		
Chlamydia		
Genital Warts		
High Blood Pressure		

Did your Mother take DES? _____

PRESENT HEALTH

Do you feel you have problems with:

	YES	NO
Menstrual Periods		
Female Organs		
Breasts		
Weight		
Ears, Eyes, Nose, Throat		
Heart		
Bladder and Kidneys		
Digestion		
Bowels		
Rectum		
Breathing		
Joints or Muscles		
Nerves		
Back		
Sleeping		
Hands or Feet		
Hair		
Depression/Anxiety		
Sex Life		
Marriage		
Other Problems		
Syphilis		
Other Serious Illness		

What medications have you taken in the past month?_____

_____

Do you regularly use any other over the counter medications? (*If yes, list*)_____

Do you use any recreational drugs? (*If yes, list*)_____

Have you ever had a problem with drug use?_____

MENSTRUAL HISTORY

Date of last menstrual period?_____ **Latest method of Birth Control?**_____

Previous methods of Birth Control?_____

Do you consider your period normal? ***Yes*** ***No*** **How often do you flow?**_____

Age started? _____ **Age at menopause?** _____ **Do you have clots?** ***Yes*** ***No***

Usual Flow: **Scant**_____ **Moderate**_____ **Heavy**_____

Pain: **None**_____ **Mild**_____ **Moderate**_____ **Severe**_____

Spotting or bleeding between periods? ***Yes*** ***No*** **Any other problems?**_____

(Over please)

PERSONAL HISTORY

Have you had a tetanus booster in the last 10 years? *Yes No* When_____
Have you had your cholesterol checked in the last 5 years? *Yes No* Result_____
Do you smoke? No_____ Yes _____ If yes, how much _____
Do you use alcohol? No _____ Yes _____ If yes, how much _____
Do you perform self breast exams? *Yes No* Would you like instruction in breast self exam? *Yes No*
How much calcium do you take in per day (Food/Supplements)?_____

What was the date of your last mammogram if applicable?_____ Result_____

Do you have yearly pap smears? *Yes No* Date of last pap smear_____ Result _____

Do you have a history of abnormal pap smears? *Yes No* (*If yes, when*)_____
What health abnormalities do you think you have?_____

Have you or your partner ever used intravenous drugs? *Yes No* Is your partner bisexual? *Yes No*
Are you sexually active with: Men_____ Women_____ Both_____
Do you feel safe at home? _____
Do you have any other health issues you would like to discuss? _____

FAMILY HISTORY

Has any blood relative had?

	YES	NO	WHO
Cancer of the breast			
Cancer of the ovaries or uterus			
Bowel cancer			
Diabetes			
High Blood Pressure			
Stroke			
Blood Diseases			
Heart Attack before age 50			
Osteoporosis			
Thyroid Problems			
Other family diseases			

PREGNANCIES

#	YEAR	MONTHS PREGNANT	TYPE OF DELIVERY MISCARRIAGE OR ABORTION	COMPLICATIONS

OPERATIONS

YEAR	OPERATION	CITY	SURGEON	COMPLICATIONS