Saint Alphonsus Medical Group

OB / GYN ANNUAL HEALTH HISTORY

Name: _____Age: ___ Date of last physical exam: _____Today's Date: _____
Phone Number _____May we leave messages on your answering machine or cell phone? ☐ YES ☐ NO
Reason for visit _____
Primary Care Physician _____ Phone _____
Physician Address _____

Medical Conditions:	**Surgery/Date**	**Meds**
		Allergies
Hospitalizations:	**Have you had a hysterectomy? Yes No**	
	Reason:	
	Have you had one or both ovaries removed? Yes No	
	Reason:	

Obstetrical and Gynecological History:

When was your last: Pap exam _____
Dexa Bone Density Scan _____
Colonoscopy _____
Mammogram _____

Number of times pregnant: _____
# of living children: _____ # of premature deliveries: _____
# of miscarriages: _____ # of abortions: _____
# of vaginal deliveries: _____ # of cesarean sections: _____
Complications? : _____
Date of last pregnancy: _____
Have you ever had Gestational Diabetes?: _____

Have you started menopause? ☐ YES ☐ NO
Do you have hot flashes? ☐ YES ☐ NO
Do you take any hormone replacements? ☐ YES ☐ NO
If yes, what type?: _____ For how long?: _____

Have you ever been told that you have osteoporosis? ☐ YES ☐ NO
Have you had any of the following:
Height loss? ☐ YES ☐ NO
Broken hip or wrist? ☐ YES ☐ NO
Do you lose urine with moving, coughing, or sneezing?
☐ Daily ☐ Weekly ☐ Rarely ☐ Never
Do you lose urine due to urgency to go to the bathroom?
☐ Daily ☐ Weekly ☐ Rarely ☐ Never
Do you have reoccurring bladder infections? ☐ YES ☐ NO
Have you ever been treated for urinary incontinence? ☐ YES ☐ NO

Are you sexually active? ☐ YES ☐ NO
If no, have you been previously? ☐ YES ☐ NO
Are your partners? ☐male ☐ female ☐both
Do you have pain with intercourse? ☐ YES ☐ NO
Have you been treated for sexually transmitted infection? ☐ YES ☐ NO
If yes, was it? ☐ chlamydia, ☐ gonorrhea ☐ herpes
☐ genital warts ☐ syphilis
Have you been treated for infection in the fallopian tubes
(pelvic inflammatory disease)? ☐ YES ☐ NO
What method of birth control do you use?: _____
Have you used "The Birth Control Pill"? ☐ YES ☐ NO
If yes, for how many years?: _____
Are you having any problem with your birth control? ☐ YES ☐ NO
_____
Are you planning a pregnancy in the next 6-12 months? ☐ YES ☐ NO

First day of last menstrual period (or first & last years of
menstruation, if through menopause): _____
How often are your periods? Every _____ days or months
How many days do you bleed with each period? _____ days
Do you have: Heavy bleeding? ☐ YES ☐ NO
Pain with periods? ☐ YES ☐ NO
Bleeding between periods? ☐ YES ☐ NO
Abnormal vaginal discharge? ☐ YES ☐ NO
Bleeding with intercourse? ☐ YES ☐ NO

Have you had: any abnormal Pap smears? ☐ YES ☐ NO
If yes, dates: _____Problem: _____
For abnormality, did you have any of the following done:
Re-check pap ☐ YES ☐ NO
Colposcopy ☐ YES ☐ NO
Cryotherapy ☐ YES ☐ NO
LEEP ☐ YES ☐ NO

People assisting with paperwork:

Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite
Name: _____
DOB: _____

Cover/AHH
Rev 04-2011
Form 0301

Patient and Provider need to Date/Time/Initial reviewed annually:

Initial review by Provider: _____/_____/_____
Date / Time / Initials

Patient: _____/_____/_____ Provider: _____/_____/_____
Date / Time / Initials Date / Time / Initials

Patient: _____/_____/_____ Provider: _____/_____/_____
Date / Time / Initials Date / Time / Initials

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Family History	High Cholesterol	High Blood Pressure	Heart Disease	Stroke	Cancer: Breast Ovary Uterus Cervix	Cancer: Colon, Lung Other	Thyroid Disease	Diabetes	Osteoporosis	Alcoholism	Depression	Blood Clots of Legs or Lungs
Grandparent												
Father												
Mother												
Aunts												
Your Brother/Sister												

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Spouse's Name:** _____

Living arrangements ☐ Alone ☐ Family/Significant Other ☐ Assisted Living ☐ Daily help needed for self care

Name of care giver _____ **Children:** How many? _____ Ages: _____

Occupation: _____ ☐ FT ☐ PT ☐ Self ☐ Retired from:_____

Level of Education: ☐ HS / GED ☐ Tech / A.A ☐ B.S. / B.A. or higher

Diet: ☐ Unrestricted ☐ Low fat ☐ Low carb / diabetic **Caffeine**: ☐ No ☐ Yes Type/Amt: _____

Sleep: # of hours per night _____ **Problems:** Falling / Staying asleep? ☐ No ☐ Yes

Exercise: ☐ No ☐ Yes Type: _____ ☐ Once a week ☐ 2-3x/wk ☐ Daily

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory ☐ Dressing
☐ Bathing ☐ Household Duties

Fall Risk: Do you have concerns about falling? ☐ No ☐ Yes Do you use any balance/mobility devices? _____

Learning Needs: Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials? ☐ No ☐ Yes Please explain: _____

_____

Abuse / Neglect: Are you experiencing neglect and/or conflict in your family and/or relationships? ☐ No ☐ Past ☐ Current

Tobacco: ☐ Never ☐ Past ☐ Current
Started: _____ Quit: _____
Packs per day? _____ ☐ Smoke ☐ Chew

Alcohol: ☐ Never ☐ Past ☐ Current
_____ # of drinks per ☐ Day ☐ Week ☐ Month

Street Drugs: ☐ Never ☐ Past ☐ Current
What? _____
Started: _____ Quit: _____

General:
☐ Anxiety/Depression
☐ Fatigue
☐ Fever or chills
☐ Migraines
☐ Weight loss / gain
☐ _____

Ears/Eyes/Throat:
☐ Ear pain or ringing
☐ Frequent nose bleeds
☐ Nasal/Sinus drainage
☐ Vision problems
☐ _____

Lungs:
☐ Cough
☐ Trouble breathing
☐ Wheezing
☐ _____

Heart:
☐ Chest pain
☐ Irregular/rapid heartbeat
☐ Pain or swelling in legs
☐ _____

Abdomen:
☐ Abnormal stools
☐ Nausea, Vomiting
☐ Pain
☐ Rectal bleeding
☐ _____

Breast:
☐ Breast lump
☐ Breast pain
☐ Nipple discharge
If yes, what was done?
_____
Do you perform breast Self-exam each month?
☐ YES ☐ NO
☐ _____

Musculoskeletal
☐ Back pain
☐ Joint pain / arthritis
☐ Difficulty with balance
☐ Difficulty with walking
Date of last fall _____
☐ _____

Skin
☐ Bruising
☐ Changing mole
☐ Skin rash
☐ _____

Place patient sticker here or handwrite

Name: _____

DOB: _____