Creekside OB/GYN of Folsom
Medical Corporation

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Name: ______________________________

Your DATE OF BIRTH:_________________

To assist us in caring for your health **please fill out** this health history form as accurately and **completely** as possible. **All your answers are strictly confidential.**

Please list what you would like to discuss during your appointment today.

1.

2.

3.

Gynecology

Question		Yes	No
How old were you when you had your first menstrual period?	**Age:**		
What was the first day of your last menstrual period?	**Date:**		
When was your last pap smear?	**Date:**		
Have you ever had an abnormal Pap smear? If yes, **please** explain what happened.			
Are you sexually active with a male / female / both / neither?			
If sexually active with a male partner what is your birth control method?			
Do you have pain or difficulty with sexual intercourse?			
Have you ever been a victim of physical abuse?			
Have you ever been a victim of sexual abuse?			
Have you ever been treated for any of the following diseases? **Please circle**	Gonorrhea Chlamydia Syphilis Herpes Genital Warts		
Have you ever been diagnosed with pelvic inflammatory disease or PID?			
Do you experience urinary leakage?			
Do you experience urinary leakage related to the feeling of urgency?			
Do you experience urinary leakage related to physical activity, coughing or sneezing?			

Please describe your typical menstrual period.

Average number of days between menses	
Length of Flow (days)	
Flow (light, moderate, heavy)	
Cramps (none, mild, moderate, severe)	

If you are menopausal, please answer the following		**Yes**	**No**
Age when you stopped menstruating?	Age:		
Are you currently on any hormone replacement?			
Have you had any unexplained vaginal bleeding since entering menopause?			
Are you experiencing vaginal dryness, hot flashes, irritable moods or irregular sleep patterns?			

Pregnancy

Please list in order ALL past pregnancies, including miscarriages, abortions, stillbirths or tubal pregnancies.

Year	Cesarean section or Vaginal delivery	Weeks Pregnant	Birth Weight lbs./oz.	Male/Female	List the hospital and any complications with the pregnancy or delivery

Medical History

Please list past and current medical problems including high blood pressure, diabetes, infections, HIV, etc.

Date/Age	Type/Name of Illness	Duration &Outcome	Doctor/Hospital

Surgical History **Please list all past surgeries (even if it is not related to gynecology)**

Date/Age	Type of Surgery	Doctor's Name	Name of Hospital or Out-Patient Clinic

Family Health

Please list any medical problems that your family members may have had (e.g. high blood pressure, diabetes, epilepsy, obesity, cancers, asthma, alcoholism, depression, genetic diseases, blood clotting disorders, etc.)

Mother
Father
Brother/Sister(s)
Grandparents
Other (Relationship)

Occupation and Hobbies

Highest level of education?______________________________

What is your current occupation?______________________________

What are some activities you enjoy most? ______________________________

Medications

List all medication you are currently taking (including non-prescription). (Please include birth control pills, aspirin, Tylenol, vitamins, antihistamines, or any alternative medications)

Name of Medication	Amount (mg., gm., tsp.)	Frequency (Number/day, week, other)

Allergies/Reaction

List any medical allergies and **describe** your allergic reaction:

	Yes	No
Are you exposed to hazards? (e.g. chemicals, solvents, dust, asbestos, fumes, lead or mercury, radiation, high stress, temperature extremes, other)		
Do you smoke tobacco? If "Yes", number of packs per day.		
Do you drink alcohol? If "Yes", number of drinks per week .		
Do you use any other drugs daily or weekly? If "Yes", which ones?		
Have you ever been kicked, punched or physically hurt by an intimate partner?		
Have you ever been forced to have sex?		
Do you have any questions about your sexual health? Please explain:		
If you are over the age of 50, have you had a colonoscopy within the last 10 years?		
Have you had a tetanus booster in the last 10 years?		
Do you do monthly self-breast exams?		
Do you currently have a dentist? If "yes", date of most recent exam:		
Do you exercise on a daily or weekly basis? If "Yes", what do you do?		
Do you use seat belts more than 75% of the time?		

I understand that this information will be part of my **confidential medical file** and will only be released according to the terms of similar medical documents.

Signature: ____

Date Completed: ____________