Contraceptive History

Are you currently sexually active? ❒ Yes ❒ No Current Contraception Method _____

Please list all methods of birth control used in the past, approximate dates, and any problems you experienced.

METHOD	DATES	PROBLEMS
Oral Pills (name)		
Condoms		
Depo Provera Injection		
Diaphragm		
Implant		
NuvaRing		
Patch		
Rhythm Method		
Partner Vasectomy		
Tubal Ligation / Essure		

Gynecological & Menstruation History

Age your periods started _____ Usual cycle every _____ days, lasting _____ days.

My periods are usually ❒ light ❒ medium ❒ heavy

My cramping is usually ❒ mild ❒ medium ❒ severe ❒ none

Have your periods stopped? ❒ Yes ❒ No If yes, when? _____

Did your periods stop on their own, or because of surgery? _____

Have you experienced any of the following conditions?

Condition	Yes	No	Dates
Bladder leakage			
Bleeding between periods			
Bleeding/pain with sex			
Breast Surgery			
Cancer of the female organs			
Chlamydia / Gonorrhea			
Cysts / Tumors			
Condyloma / Warts			
Fibroids			

Condition	**Yes**	**No**	**Dates**
HPV			
Herpes			
HIV / AIDS			
Infertility			
Pelvic Surgery			
Pelvic Infection (PID)			
PMS			
Syphilis			
Vaginal Infection			

Date of last pelvic exam _____ Date of last Pap Smear _____ Normal? ❒ Yes ❒ No

Have you ever had an abnormal Pap Smear? ❒ Yes ❒ No If yes, when? _____

As a result of your abnormal Pap, did you have a Colposcopy or LEEP procedure? If so, when? _____

Date of last breast exam _____ Date of last mammogram _____ Normal? ❒ Yes ❒ No

Pregnancy History

I have never been pregnant ❒

I have been pregnant _____ times (please complete any previous pregnancy history below)

Dates	Weeks	Wt (lb/oz)	Sex	Place	Anesthesia	Complications (miscarriage/abortion, etc)

Deliveries (total): _____ Vaginal: _____ Cesarean: _____

Complications of Pregnancy? _____

Do you plan on having children in the future? ❒ Yes ❒ No ❒ Undecided

GOLDEN GATE
OBSTETRICS & GYNECOLOGY

HEALTH HISTORY FORM

Name _____

Date of Birth _____

General Medical History

Have you experienced any of the following medical conditions?

Condition	Yes	No	Dates
Anemia			
Allergies			
Asthma			
Blood Clots			
Cancer			
Chest Pain			
Depression			
Epilepsy			
Eye Disease			
Gall Bladder Disease			
Genetic Disorders			
Heart Problems			
Hepatitis A, B, C			

Condition	Yes	No	Dates
Kidney Problems			
Liver Disease			
Migraines			
Obesity			
Osteoporosis			
Pulmonary Disease (TB)			
Rheumatic Fever			
Sickle Cell Anemia			
Thyroid Disease			
Urinary Tract Infection			
Varicose Veins			
Vertigo / Dizziness			
Diabetes			
High Blood Pressure			

Have you had the MMR vaccine? ❒ Yes ❒ No

Are you currently taking any medication? ❒ Yes ❒ No

If yes, please name all medications and dosage: _____

What is your preferred pharmacy & location? _____

Do you smoke cigarettes? ❒ Yes ❒ No If yes, how many cigarettes per day? _____

Do you take drugs ❒ Yes ❒ No If yes, please name _____ How often? _____

Do you drink alcohol? ❒ Yes ❒ No If yes, how much? _____

Are you allergic to any medication? ❒ Yes ❒ No If yes, please name: _____

List all past surgeries: _____

Family History

If adopted or you have an unknown family history, check here ❒

Please indicate Mother's (M) or Father's (F) side of the family:

Condition	(M)	(F)	Family Member	Date of Illness
Breast Cancer				
Colon Cancer				
Ovarian/Uterine Cancer				
Skin Cancer				
Other Cancer				
Depression				
Diabetes (Type I or II)				
Genetic Disorder				
Heart Disease				
Hypertension				
Stroke				

Please complete other side ➔