Stanford MEDICINE

Stanford Medicine - Women's Health - Redwood City

OB/GYN MEDICAL HISTORY FORM

Medical Record Number:
Patient name

Label

The information on this sheet is confidential

Name:	Date of Birth:	Referred by:

MENSTRUAL History:

Age Started	Flow Type	Cycle length	Any of the following:	
	☐Light ☐Average ☐Heavy	*(Days between 1st day of periods)*	☐ PMS ☐ Menstrual cramps	☐Bleeding between periods ☐Pain with intercourse

GYNECOLOGICAL History

Age of first sexual encounter:	Total # of partners: _____ ☐Male ☐Female ☐Both	Currently sexual active? ☐Yes ☐No	Date of last pap smear:
Received HPV Vaccine: ☐Yes ☐No	Birth Control:		
History STDs ☐Herpes Chlamydia ☐Gonorrhea ☐HPV ☐HIV	☐None/trying to conceive ☐Condoms ☐Pill ☐Nuva Ring	☐ Patch ☐Tubal Ligation ☐Vasectomy ☐Natural Family Planning	☐Nexplanon date placed: _____ ☐IUD date placed: _____ ☐Skyla ☐Kyleena ☐Mirena ☐Paragard
What form of birth control have you used in the past? When?			

If postmenopausal

When was your last period:	Hormone therapy? ☐Yes ☐No If yes, currently using:
What form of hormone therapy have you used in the past? When?	

Any of the following: *please mark w 'X' and write details in the space provided*

	Abnormal pap		Ectopic pregnancy		Endometriosis		Genital warts
	Infertility		Irregular periods		Ovarian cysts		Recurrent miscarriage
	Fibroids		Vaginal discharge		Vaginal infections		Vulvar pain

Details:

OBSTETRIC History

Number of pregnancies:	Vaginal deliveries:	Cesarean sections:	Miscarriages:
Elective terminations:	Premature births:	Stillborns:	

Pregnancies

#	Date	Wks at delivery	Delivery type	Baby weight	Sex	Complications
1						
2						
3						
4						
5						

SOCIAL History:

Marital status:
☐Married ☐Single ☐Divorced
☐Widowed ☐Domestic partnership
Patient ethnicity: _____
Partner's ethnicity:_____
Patient Occupation: _____
Patient Employer: _____

Habits:
Smoker: ☐Current ☐Former ☐Never
if current smoker, how many/day? _____
if previous smoker, when did you quit? _____
Recreational drugs: _____
Alcohol: #drinks _____ per ☐day ☐week ☐month
Exercise? Times/week? _____

Last Mammogram:	Last Colonoscopy:	Last Bone density test:	Last Tetanus Shot:	Last Flu Shot:

Other Physicians:

Please complete reverse side.

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MEDICAL History: *please mark any positives and write details in the space provided*

	Allergies		Depression		Hemorrhage		Kidney stones
	Anemia		Postpartum depression		Blood transfusion		Liver disease
	Anxiety		Diabetes (type 1 or 2)		High cholesterol		Hepatitis
	Asthma/lung disease		Eating disorder		Hypertension		Osteoporosis
	Cough		Epilepsy		Irritable bowel syndrome		Positive TB screening
	ADHD		Gastritis/ulcer		Change in bowels		Tuberculosis
	Cancer		GERD (reflux)		Blood in stool		Stroke
	Breast problem		Gestational diabetes		Hyperthyroidism		Bladder infections
	Cholecystitis (gall bladder)		Heart disease		Hypothyroidism		Kidney disease
	Blood coagulation defect/hemophilia		Headaches (tension/migraine)		Urinary incontinence/poor bladder control		Other:
Details:							

SURGICAL History: Please record any surgical procedures and the approximate dates

MEDICATIONS: Please list all current prescription medications and doses; also list over the counter medications and supplements

ALLERGIES TO MEDICATIONS: NONE / or list and what reaction you had?

FAMILY History: If yes please mark with 'X'

	Cancer	List relative, maternal or paternal	Age of diagnosis if known
	Breast		
	Uterine		
	Ovarian		
	Cervical		
	Colon		
	Other Gastrointestinal		
	Other		

	Disease	List relative, maternal or paternal	Age of diagnosis if known
	Diabetes		
	Hypertension		
	Heart disease		
	Stroke		
	Genetic disorder		

Signature: _____ Date: _____

I have read my MEDICAL HISTORY above and confirm that it adequately states past and present condition.