Texas Health Physicians Group
Her OB/GYN

PATIENT HISTORY FORM

Name_____ **Date of Birth**_____

Reason for today's visit _____

_____

Allergies _____

Medical History (Diabetes, Asthma, etc)

_____

_____

Surgical (Tonsillectomy, Hysterectomy, etc.) None

_____

_____

Allergies to medications? None

Current prescription medicines

Name of drug mg does # tablets # times per day

_____ _____ _____ _____

_____ _____ _____ _____

OTC medicines (Aspirin, Tylenol, Ibuprofen, vitamins)

_____ _____ _____ _____

_____ _____ _____ _____

Family History

Father: Living - Age: _____ Deceased, Age at Death _____
(Cause) _____
Mother: Living - Age: _____ Deceased, Age at Death _____
(Cause) _____
Siblings: Number Living _____ Number deceased _____
List other illnesses in your family
Family Member _____ Illness _____
Family Member _____ Illness _____
Family Member _____ Illness _____

Social History

Smoke? Yes No If yes, how much? _____ # of packs/day

_____ # of years When did you stop smoking? _____

Alcohol? Yes No If yes, how much? _____

Exercise regularly? Yes No If yes, what and how frequently?

_____

Routinely wear **seatbelts**? Yes ☐ No ☐
Routinely wear a **helmet**? Yes ☐ No ☐
Substance Abuse? Yes ☐ No ☐

Have you ever had a pap smear? Yes ☐ No ☐
Date of last pap smear _____ results _____
History of abnormal pap smear? Yes ☐ No ☐
Abnormal pap smear follow up: _____
What was the **first** day of your last menstrual period? _____
Was your last period normal? Yes ☐ No ☐
How often do you get your period? _____
How long does it last? Menstrual flow: light ☐ heavy ☐
Do you have painful periods? Yes ☐ No ☐
How do you manage the pain? _____
Do you miss periods? Yes ☐ No ☐
Do you have bleeding between periods? Yes ☐ No ☐
PMS symptoms? _____
Do you think you could be pregnant now? Yes ☐ No ☐
Total number of pregnancies ___ living children ___ abortions ___
Miscarriages ___
Do you currently have:
unusual vaginal discharge: No ☐ Yes, color _____
vaginal / genital: itching ☐ odor ☐ sores ☐ bumps ☐ rash ☐
Pain or bleeding with intercourse? Yes ☐ No ☐
Pain or pressure in abdomen or back? Yes ☐ No ☐

Sexual / Contraceptive History

Age at first sexual intercourse _____
Have you ever had sexual contact? Yes ☐ No ☐
If yes, with: men ☐ women ☐ both ☐ vaginal ☐ anal ☐ oral ☐
Sexual active this past year? Yes ☐ No ☐
Length of time with current or most recent partner: _____
> 1 partner this past year? Yes ☐ No ☐
Number of lifetime partners: _____
Condom use: always ☐ sometimes ☐ never ☐
Have you ever been tested for STI's? Yes ☐ No ☐
Have you or your partner ever had? chlamydia ☐ gonorrhea ☐
herpes ☐ genital warts (HPV) ☐ Hepatitis B ☐
Do you want to be tested for sexually transmitted infections today?
Yes ☐ No ☐

Birth control

What birth control methods are you currently using?
(include condoms, spermicides, etc.) _____
Are you having any problems with this methods? _____
Birth control method requested today _____

Signature _____ Date _____

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o

Constitutional Symptoms			**Integumentary**		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Boils	Y	N
Headache	Y	N	Persistent itch	Y	N
Other _____			Other _____		
Eyes			**Musculoskeletal**		
Blurred vision	Y	N	Joint pain	Y	N
Double vision	Y	N	Neck pain	Y	N
Pain	Y	N	Back pain	Y	N
Other _____			Other _____		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Y	N	Ear infection	Y	N
Drug allergies	Y	N	Sore throat	Y	N
Other _____			Sinus problem	Y	N
			Other _____		
Neurological					
Tremors	Y	N	**Genitourinary**		
Dizzy spells	Y	N	Urine retention	Y	N
Numbness/tingling	Y	N	Painful urination	Y	N
Other _____			Urinary frequency	Y	N
			Other _____		
Endocrine					
Excessive thirst	Y	N	**Respiratory**		
Too hot/cold	Y	N	Wheezing	Y	N
Tired/sluggish	Y	N	Frequent cough	Y	N
Other _____			Shortness of breath	Y	N
			Positive TB		
Gastrointestinal			Other _____		
Abdominal pain	Y	N			
Nausea/vomiting	Y	N	**Hermatologic/Lymphatic**		
Indigestion/heartburn	Y	N	Swollen glands	Y	N
Other _____			Blood clotting problem	Y	N
			Other _____		
Cardiovascular					
Chest pain	Y	N	**Psychologic**		
Varicose veins	Y	N	Are you generally satisfied with your life?	Y	N
High blood pressure	Y	N	Do you feel severely depressed?	Y	N
			Have you considered suicide?	Y	N
Last Eye & Dental Exam					
			Sexual History		
Date – Last Eye Exam: _____			Change of sex drive?	Y	N
			Sexual performance satisfactory?	Y	N
Date – Last Dental Exam: _____			Other (i.e. sexual trauma)	Y	N

Screening Exams

Cholesterol	Colonoscopy	Mammogram	Pelvic Exam
PSA	Chest X-ray	Stress Test	Blood Pressure