Rocky Mountain OB-GYN
UNIVERSITY OF COLORADO

MEDICAL HISTORY INFORMATION SHEET

Today's date_____

Age_____ **Date of birth**_____

Name_____

Any concerns/issues you would like to discuss today?

GYNECOLOGY HISTORY G___P_____

First day of last menstrual period?	
Age at 1st period	
# of days between periods (from 1st day of period to 1st day of next period)	
Length of period (# of days of bleeding)	
Heavy bleeding?	Y / N
Cramps?	Y / N

Birth control method N/A	
Number of sexual partners in last year	
Are you currently sexually active?	Y / N
With whom do you have sex? Males only/ Females only Both Males and Females	
Have you had any sexually transmitted diseases? If yes, which ones?	Y / N
Would you like to be tested today?	Y / N

When was your last pap smear?	
Any history of abnormal pap smears? When was this? What treatment was performed?	Y / N
When was your last mammogram? N/A	

Any history of sexual abuse or domestic violence?	Y / N
Do you feel safe in your current relationship?	Y / N
Would you like to talk about this today?	Y / N

If you are in menopause:

When did this begin?	
Which hormone replacement therapy are you taking? N/A	
What symptoms are you having? Please circle Hot flashes Vaginal dryness Night sweats Vaginal bleeding Low libido Insomnia Mood changes	

OBSTETRIC HISTORY- No changes
List all previous pregnancies

PAST MEDICAL HISTORY - No changes
List all medical problems

PAST SURGICAL HISTORY- No changes
List all previous surgeries

Primary Care Doctor: _____

MEDICATIONS
List all medications, herbs or supplements

ALLERGIES to any medicines

SOCIAL HISTORY

Marital status			
Occupation?			
With whom do you live?			
Smoke?	Y / N	How many packs a day?	
Drink alcohol?	Y / N	How many drinks a week?	
Do drugs?	Y / N	Which drugs?	
Do you exercise?	Y / N	What kind and how often?	
Use sunscreen?	Y / N		
Use a seatbelt?	Y / N		
Calcium in your diet?	Y / N		
Had the HPV vaccine? (if you are 26 or younger)	Y / N	If not, would you like this?	Y / N

FAMILY HISTORY-Please circle if you have any family members with the following:

Breast cancer	Uterine cancer	Ovarian cancer
Colon cancer	Stroke	High blood pressure
Heart disease	Blood clots	Diabetes
Osteoporosis	Birth defects	Other:

PREVENTATIVE

Have you had the following test?	When was this test last done?
Cholesterol	
Diabetes	
Thyroid	
Colonoscopy	
Bone density	

REVIEW OF SYSTEMS- Please circle
NONE OF THE BELOW

Fever	Fatigue	Hair loss
Chest pain	Cough	Shortness of breath
Palpitations	Feeling hot/cold	
Breast pain	Breast lump	Nipple discharge
Diarrhea Constipation	Blood in stools	Nausea/ vomiting
Pain with urination	Frequent urination	
Urge to urinate	Blood in urine	
Loss of urine/incontinence	Change in height	Sleep difficulties
Cuts that don't stop bleeding	Weight loss/gain	
Rashes or skin lesions	Depression or anxiety	