Lifespan Physician Group Inc. – Obstetrics & Gynecology
Health History Form

Name: _____ DOB:_____ Age: _____ Today's Date: _____

I prefer to be called: _____ Pronouns:_____ Referred by: _____

Reason for visit (current concerns): _____

Medications: (List all, including dose if you know it. Please include vitamins, supplements, and over-the-counter medications):

_____

_____

Allergies (to medications or other types of allergies): _____

_____

Personal and family medical history (please check all that apply):

	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF	Uncle/ Aunt/ Other
Heart disease/Heart attack									
Stroke									
Diabetes									
High blood pressure									
High cholesterol									
Thyroid disease									
Breast cancer									
Ovarian cancer									
Other cancer									
Osteoporosis									
Asthma									
Tuberculosis									
Blood clot or bleeding disorder									
Endometriosis									
Infertility									
High blood pressure in pregnancy									
Intestinal problems									
Kidney stones or infection									
Bladder problems									
Lupus									
Migraines									
Seizures or epilepsy									
Anorexia, Bulimia, or other eating disorder									
Depression									
Anxiety									
Substance or alcohol use disorder									
Blood transfusion									
Other: _____									

Surgeries or hospitalizations: _____

_____

Social History

Relationship status: _____ Sexual orientation: _____ Gender identity: _____

My sexual partners are (circle): Female Male Both Other _____ NA

How many sexual partners have you had in the last year? _____ In your lifetime? _____

Do you use barrier methods (condoms, dental dams, etc.) during sex? Y N

How many alcoholic drinks do you have a day? _____A Week?_____ Type? _____

Are you a current smoker? Y N # Cigarettes per day: _____ Former smoker? Y N Quit date _____

Current E-Cigarette Use? Y N Former smoker? Y N Quit date _____

Do you use drugs or take non-prescribed pills (like cocaine or pain pills? Y N Former Use Y N

How many times a week do you exercise? _____ What type of exercise? _____

What is your calcium intake like? _____ # of caffeinated drinks in a day? _____

Health Maintenance

	Date	**Result**		**Date**
Last Pap Smear			Last Colonoscopy	
Last STD Test			Last Regular Physical	
Last Mammogram			Last Dental Exam	
Last Bone Density Scan			Last Eye Exam	

Have you received the HPV Vaccine (Gardasil)? Y N Unsure

Safety

Do you feel safe in your intimate relationships? Y N

Do you feel safe at home? Y N

Do you wear seatbelts? Y N

Do you wear sunscreen? Y N

Family Planning and Birth Control

Do you want to become pregnant? Y N

Do you currently use birth control? Y N NA

Current birth control:_____

Please check any past birth control methods you have tried:

❑ Condoms ❑ Birth control pills ❑ Patch ❑ NuvaRing ❑ Other

❑ Depo Provera shot ❑ Nexplanon ❑ Paragard IUD ❑ Hormonal IUD (Mirena/Kyleena/Skyla/Liletta)

Gynecologic History

Age at first period: _____ First day of your last period: _____

# of days from start of your period to the start of the next period: _____ # of days of flow: _____

Excessive bleeding? Y N

Excessive cramping? Y N

History of abnormal Pap smears? Y N

History of abnormal mammograms? Y N

Describe: _____

Describe: _____

Please check any you have had:

❑ Herpes ❑ HPV ❑ Warts ❑ Chlamydia ❑ Gonorrhea

❑ HIV ❑ Hepatitis ❑ Syphilis ❑ Trich

Pregnancy History

# of pregnancies _____ # of full-term births _____ # of preterm births _____ # of living children _____

# of miscarriages _____ # of abortions _____ #C sections _____ forceps or vacuum? _____

Past pregnancy complications: _____