CONTEMPORARY women's HEALTH™
10031 Sherrill Blvd | Knoxville | TN 37932 | p: 865.540.1650 | f: 865.246.4755

OB/GYN HISTORY FORM

Chart# _____

Name:	**Date of Birth:**	**Age:**	**Date:**

PAST MEDICAL HISTORY

	Yes	No	Date			Yes	No	Date
Anemia					Hypertension (High blood pressure)			
Asthma					Hyperthyroidism			
Hospitalized for Asthma					Hypothyroidism			
Breast Cancer					Irritable Bowel Syndrome			
Breast Cyst, Benign					Kidney Calculus/Stone			
Chickenpox					Migraine			
Cholelithiasis					Mitral Valve Prolapse			
Coronary Artery Disease					Osteopenia			
Deep Vein Thrombosis					Osteoporosis			
Depression					Peptic Ulcer Disease			
Diabetes Mellitus					Previous Blood Transfusion			
Diverticulosis of Colon					Why transfused?			
Emphysema					Pulmonary Embolism			
Epilepsy					Sickle Cell Anemia			
Fibrocystic Changes of Breast					Tuberculosis			
Glaucoma					Uterine Fibroids			
Hepatitis					Urinary Tract Infection (UTI)			
Human Immunodeficiency Virus (HIV)					**Other:**			
Elevated cholesterol								
Hypercoagulation Syndrome								

PAST SURGICAL HISTORY

List Surgery	**Date**

ALLERGIES/REACTION

Allergy to	**Reaction caused**

GYNECOLOGIC HISTORY

Yes	No		Date		Yes	No		Date
		Abnormal Pap Smear					Any Sexually Transmitted Diseases	
		Abnormal Bleeding/Irregular Bleeding			**If yes, type:**			
		Endometriosis					Pelvic Inflammatory Disease	
If yes, how was it diagnosed?:					**If yes, type**			
Other:					**Other:**			

MENSTRUAL HISTORY

Age Started Period:
Last Menstrual period:
How often : How long:
Birth control method:
Menopause? **Yes** **No** If yes, at what age?

SCREENING TESTS

	Yes	No	Date	Result
Colonoscopy				
Dexascan				
Mammogram				
Pap Smear				

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Name:	Date of Birth:	Age:	Date:

SOCIAL HISTORY

	Yes	No
Smoke If yes, _____ pk/day for _____ years		
Drink Alcohol If yes, _____ oz/day for _____ years		
Any Drug Use If yes, _____ type: _____		
Caffeine		
Wear Seat Belt		
Get Calcium In Diet		
Domestic Violence(Past or Present)		
Married		
Adopted		
Occupation:		

VACCINES **(Are you up to date on the following vaccinations?)**

	Yes	No
Hepatitis A		
Hepatitis B		
HPV		
MMR/Rubella		
Seasonal Flu		
Tetanus, Diphtheria, Pertussi		

PREGNANCY HISTORY

Total Number of pregnancies:		
# of Full Term:	# of Premature:	
# of Miscarriages:	# of Abortions:	
Type of Delivery(s)	**Weight**	**Date**
If Cesarean please give reason:		
Any other problems during pregnancy?:		

FAMILY HISTORY

	Yes	No	Relative/Age
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Osteoporosis			
Ovarian Cancer			
Stroke			
Thyroid Disease			
Other:			

MEDICATIONS **(Prescriptions, Vitamins, Herbal/Alternative Meds)**

Current Medication	Dosage	Indication	Prescribed by:

Please feel free to write down anything we may not have asked that you feel is important to include in your chart: