Stanford MEDICINE
Women's Care Medical Group

OB/GYN MEDICAL HISTORY FORM

Medical Record Number

Patient Name

Addressograph or Label

The information on this sheet is confidential

A. OB/GYN HISTORY:

YOUR MENSTRUAL HISTORY (WHEN NOT TAKING BIRTH CONTROL PILLS):

AGE STARTED	NO. DAYS OF FLOW			AMOUNT OF FLOW	ANY CRAMPS	ANY PRE-MENSTRUAL TENSION	MENSTRUAL CYCLE (NO. OF DAYS FROM FIRST DAY OF ONE PERIOD TO FIRST DAY OF NEXT PERIOD)	ARE YOUR CYCLES	
	LIGHT	AVE	HEAVY					REGULAR	IRREGULAR

YOUR PREGNANCY HISTORY:

TOTAL NO. OF PREGNANCIES	NO. OF LIVE BIRTHS	NO. OF PREMATURES	NO. OF		NO. OF STILLBIRTHS	AGES OF	
			MISCARRIAGES	ABORTIONS		OLDEST	YOUNGEST

Problems with pregnancy? _____

What method of contraception are you and your partner using now? _____ Painful intercourse? □ Yes □ No

B. MEDICAL HISTORY:

Please answer ALL questions by checking "YES" or "NO" in the appropriate box provided.

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Heart Trouble	□	□	Cortisone Medicine	□	□	Venereal Disease	□	□	Hemophilia
□	□	Heart Murmur	□	□	Diabetes	□	□	AIDS	□	□	Allergies
□	□	Mitral Valve Prolapse	□	□	Blood Transfusion	□	□	Herpes	□	□	Pelvic Infection
□	□	Rheumatic Fever	□	□	Ulcers	□	□	Asthma	□	□	Psychiatric Care
□	□	Heart Surgery	□	□	Kidney Trouble	□	□	Lung Disease	□	□	Nervousness
□	□	Stroke	□	□	Liver Disease	□	□	Phlebitis	□	□	Fainting or Dizziness
□	□	High Blood Pressure	□	□	Glandular Disease (Thyroid, etc.)	□	□	Blood Disease	□	□	Tuberculosis
□	□	Low Blood Pressure	□	□	Hepatitis B (serum)	□	□	Anemia	□	□	Chest Pain, Shortness of Breath
□	□	Breast Problem	□	□	Yellow Jaundice	□	□	Poor Bladder Control	□	□	Blood in Stool
□	□	Abnormal Pap	□	□	Drug Addiction	□	□	Excessive Alcohol Intake	□	□	Rapid Weight Loss
□	□	Epilepsy or Seizures	□	□	Smoking	□	□	In-utero DES Exposure	□	□	Change in Bowel/Bladder Habits
□	□	Cancer	□	□	Change in Mole/Wart	□	□	Nagging Cough, Hoarseness	□	□	Difficulty in Swallowing

Other medical problems? □ Yes □ No Describe: _____

Have you ever had any operations or surgical procedures? _____

Are you under another doctor's care? _____

Allergy (to Medication) _____ Medications taken regularly _____

C. FAMILY HISTORY:

Has any relative ever had…

Cancer Of:	Yes	No	Who		Yes	No	Who
Breast	□	□		Diabetes	□	□	
Uterus	□	□		Heart Trouble	□	□	
Ovary	□	□		High Blood Pressure	□	□	
Cervix	□	□		Stroke	□	□	
Colon/Stomach	□	□		Epilepsy	□	□	
Others	□	□		(others)	□	□	

Patient Signature x _____

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