AGAPE
FAMILY HEALTH

OB / GYN ANNUAL HEALTH HISTORY

Name:_____ Age: _____ Date of Last Physical Exam: _____ Today's Date:_____

Obstetrical and Gynecological History:

When was your last: Pap exam _____
Dexa Bone Density Scan _____
Colonoscopy _____
Mammogram _____

Number of times pregnant: _____
# of living children: _____ # of premature deliveries: _____
# of miscarriages: _____ # of abortions: _____
# of vaginal deliveries: _____ # of cesarean sections: _____
Complications? : _____
Date of last pregnancy: _____
Have you ever had Gestational Diabetes?: _____

Are you sexually active? ☐ YES ☐ NO
If no, have you been previously? ☐ YES ☐ NO
Are your partners? ☐male ☐female ☐both
Do you have pain with intercourse? ☐ YES ☐ NO
Have you been treated for sexually transmitted infection? ☐ YES ☐ NO
If yes, was it? ☐chlamydia, ☐ gonorrhea ☐herpes
☐ genital warts ☐syphilis
Have you been treated for infection in the fallopian tubes (pelvic inflammatory disease)? ☐YES ☐ NO
What method of birth control do you use?: _____
Have you used "The Birth Control Pill"? ☐YES ☐ NO
If yes, for how many years?: _____
Are you having any problem with your birth control? ☐YES ☐ NO
_____
Are you planning a pregnancy in the next 6-12 months? ☐YES ☐ NO

Have you started menopause? ☐YES ☐ NO
Do you have hot flashes? ☐YES ☐ NO
Do you take any hormone replacements? ☐YES ☐ NO
If yes, what type?: _____ For how long?: _____

Have you ever been told that you have osteoporosis? ☐ YES ☐ NO
Have you had any of the following:
Height loss? ☐ YES ☐ NO
Broken hip or wrist? ☐ YES ☐ NO
Do you lose urine with moving, coughing, or sneezing?
☐Daily ☐Weekly ☐Rarely ☐Never
Do you lose urine due to urgency to go to the bathroom?
☐Daily ☐Weekly ☐Rarely ☐Never
Do you have reoccurring bladder infections? ☐YES ☐ NO
Have you ever been treated for urinary incontinence? ☐YES ☐ NO

First day of last menstrual period (or first & last years of menstruation, if through menopause): _____
How often are your periods? Every _____ days or months
How many days do you bleed with each period? _____ days
Do you have:
Heavy bleeding? ☐ YES ☐ NO
Pain with periods? ☐ YES ☐ NO
Bleeding between periods? ☐ YES ☐ NO
Abnormal vaginal discharge? ☐ YES ☐ NO
Bleeding with intercourse? ☐ YES ☐ NO

Have you had: any abnormal Pap smears? ☐YES ☐ NO
If yes, dates: _____Problem: _____
For abnormality, did you have any of the following done:
Re-check pap ☐ YES ☐NO
Colposcopy ☐ YES ☐NO
Cryotherapy ☐ YES ☐NO
LEEP ☐ YES ☐ NO