Main Line HealthCare

OB/GYN Medical History Form

Patient Name:_____ Practice:_____

Patient DOB:_____ Provider:_____

Patient Sex: ☐ Male ☐ Female

Active Medications ☐ No Medications

*** Complete as much medication information as possible**

	Brand/Generic Name	Start Date	Dose	SIG
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies ☐ No Known Allergies **Problems List** ☐ No Chronic Problems

	Name	Reaction
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

	Name	ICD-9	Additional Information
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Main Line HealthCare

OB/GYN Medical History Form

Patient Name: _____ Patient DOB: _____

Medical/Surgical History

☐ No Known Past Medical History

	Disease	Year Dx	Mgmt/Procedure	Year Proc	Outcome/Status
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Family History

☐ No Relevant Family History

	Family Member	Diagnosis/Problem	Age Onset	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Social History

Tobacco Use ☐ yes ☐ no ☐ former

Type	
Packs/Day	
Years Smoked	
Years Quit	

Drinks Alcohol ☐ yes ☐ no ☐ former Years Quit ☐

Type		Frequency	
Amount		Last Drink	

Caffeine Use ☐ yes ☐ no

Type		
Amt Daily		

Preferred Pharmacy Information

	Pharmacy Name	Phone	Fax	Address
1				
2				

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Patient Name: _____ Patient DOB: _____

Gynecologic History

Age of Menarche ☐ Date of Last PAP ☐ Date of last Mammo ☐

☐ normal ☐ abnormal ☐ normal ☐ abnormal

Premenopausal ☐ yes ☐ no

Perimenopausal ☐ yes ☐ no

Postmenopausal ☐ yes ☐ no Age ☐ Year ☐ Type ☐

Hysterectomy ☐ yes ☐ no Type ☐

Pregnancy History

Full Term ☐ Premature ☐ Abortions ☐

Miscarriages ☐ Tubal-Ectopic ☐ Living Children ☐

Birth History

Preg #	Sex	Year	Gestational Age	Weight	Delivery Type	Complications/Comments

Contraception/Safer Sex History

Sexual Orientation ☐

Sexually Active yes no Previously

Practices Safer Sex ☐ yes ☐ no ☐ Sometimes

Type of Birth Control

☐ Condoms ☐ Birth Control Pill ☐ Tubal

☐ Diaphragm ☐ Ring ☐ Injection

☐ IUD ☐ Vasectomy ☐ Other: ☐