New Braunfels OB/GYN

Name: ________________________ Date of Birth: ____________

Allergies to medications: ____

Current medications & supplements (w/ dosages if known): ______________

____

____

Medical History:

Please check if you have problems in the following areas. Enter details in space below.

__ Heart
__ High blood pressure
__ High cholesterol
__ Lungs
__ Asthma
__ Stomach/intestines
__ Kidney/bladder
__ Osteoporosis
__ Muscular
__ Diabetes
__ Thyroid
__ Migraine Headaches
__ Seizures
__ Bleeding disorder
__ Blood clots

__ Cancer
__ Depression
__ Mental health history
__ Anxiety
__ Hepatitis
__ HIV
__ Gynecologic
__ Bleeding between periods
__ Problems with current birth control
__ Pain w/ intercourse
__ Pain w/ periods

__ Sexually transmitted diseases
__Breast lump
__Recurrent UTI
__Recurrent Vaginal infections
__PCOS
__Ovarian Cysts
__Anemia
__Fibroids
__Incontinence (leakage of urine)
__Pelvic Organ Prolapse

Details: ____

OB/GYN history:

How many times have you been pregnant? (do not include current pregnancy) ______

Have you ever had any miscarriages? (# of) _______ or abortions? _____

How many deliveries have you had?_____ # of deliveries prior to 37 weeks? ______

Method of delivery? # of Vaginal ______ and/or # of C-Section ______

Did you have any problems during pregnancy?______________________

How many children do you have?______ How many step children? ______

At what age did you have your first period? _____ Date last period started: __________

How many days does your period last?_____ Do you have regular cycles?______

Is your period bleeding light , moderate or heavy?___________

If menopausal, how old were you when you went through menopause? ______

What method of birth control are you currently using?

___Abstinence (no intercourse)
___Birth Control Pills
___Condoms/spermicide
___Nuva Ring

___Pull out method
___Rhythm method
___Diaphragm
___Depo Provera

___Tubal ligation
___Hysterectomy
___Vasectomy in partner
___Nexplanon

___Essure (date)_____________ ___IUD (date)______________ ___Attempting pregnancy

When was your last pap smear? _______________ Were results normal? Yes No

Have you ever had an abnormal pap? Yes No When? __________

Did abnormal pap show 1 or more of the following? (circle if known) HPV ASCUS Dysplasia

For abnormal pap, did you have any of the following done?

Colposcopy	Yes	No	When? __________
Biopsies	Yes	No	When? __________
Cone biopsy	Yes	No	When? __________
Laser	Yes	No	When? __________
Freeze (cryo)	Yes	No	When? __________

Have you ever had a mammogram? Yes No When? ________________

Have you ever had an abnormal mammogram? Yes No When? ________________

For abnormality, did you have? Ultrasound Yes No Results? _____________

Biopsy Yes No Results? _____________

How often do you perform self breast exams? __________________

Surgical History (with date of surgery, include C-Sections if any):

____

____

Family history (circle mother/father, brother/sister, maternal/paternal grandparent):

__ Diabetes	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF
__ High blood pressure	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF
__ Heart attack	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF
__ Stroke/Blood Clot	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF
__ Osteoporosis	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF
__ Depression	Mom	Dad	Bro	Sis	MGM	MGF	PGM	PGF

Family history of gynecologic cancers (parent, brother/sister, grandparent, aunt/uncle only):

__ Breast **Who?** ____

__ Ovarian **Who?** ____

__ Uterine **Who?** ____

__ Colon **Who?** ____

__ Other Cancer type & Who ____

Have you ever used tobacco? Yes No If yes # of packs/day? ____ or # of cigarettes/day?____

Number of years smoked? _____ Current tobacco user? Yes No Date quit?(MM/YY)_________

Do you consume alcoholic beverages? Yes No Very Rarely

# of servings/day? _____ **or** # of servings/week? _____ **or** # of servings/month? _____

Do you drink caffeine? Yes No Very Rarely

How many servings of caffeine/day?____________

Have you ever used illegal drugs? YES NO

How would you characterize use? (circle one) Experimentation Regular use Addict

If current user, what type and how often? ____

If past user, what type and when last used? ____

Have you ever been diagnosed with a sexually transmitted infection? YES NO

If so, which one(s)? ____

Signature____ **Date** ____________________