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					Elevated cholesterol			
Asthma					Hypercoagulation Syndrome			
Hospitalized for Asthma					Hypertension (High blood pressure)			
Breast Cancer					Hyperthyroidism			
Breast Cyst, Benign					Hypothyroidism			
Chickenpox					Irritable Bowel Syndrome			
Cholelithiasis					Kidney Calculus/Stone			
Coronary Artery Disease					Migraine			
Deep Vein Thrombosis					Mitral Valve Prolapse			
Depression					Osteopenia			
Diabetes Mellitus					Osteoporosis			
Diverticulosis of Colon					Peptic Ulcer Disease			
Emphysema					Previous Blood Transfusion			
Epilepsy					Why transfused?			
Fibrocystic Changes of Breast					Pulmonary Embolism			
Glaucoma					Sickle Cell Anemia			
Hepatitis					Tuberculosis			
Human Immunodeficiency Virus (HIV)					Urinary Tract Infection (UTI)			
Other:					**Other:**			

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 Disesases	
		Abnormal Bleeding/Irregular Bleeding			**If yes, type:**			
		Endometriosis					Pelvic Inflammatory Disease	
If yes, how was it diagnosed?:					**If yes, type**			
Other:					**Other:**			

MENSTURAL 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, Diptheria, 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	Realative/Age
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Colesterol			
Osteoporosis			
Ovarian Cancer			
Stroke			
Tyroid Disease			
Other:			

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

Current Medication	Dosage	Indiccation	Prescribed by:

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