MOUNTAINSTAR Healthcare

Lakeview OB/GYN Clinic

Lakeview OB/GYN
Gynecology and Women's Healthcare

Name: Age:

(First) (Last) (Maiden)

Reason for today's visit: Today's Date:

Gynecology History

Date of last Period _____

How often do you have your period?_____

How many days do they last? _____

Are your periods painful?_____

What do you use for birth control?_____

Are you currently sexually active? Yes_____ No_____

Have you gone through menopause? Yes_____ No_____

Last pap smear?_____

Any abnormal paps? _____

Last bone density scan?_____

Last cholesterol test?_____

Last colonoscopy?_____

Pregnancy History

How many times have you been pregnant?_____

How many miscarriages?_____

Have you had any c-sections? Yes_____No_____

How many live births?_____

How many abortions?_____

If yes, how many?_____

Medical History

Are you allergic to any medications? Yes____ No____

If yes, please list:_____

Cancer_____ Heart disase:_____ High blood pressure:_____

Asthma:_____ Bowel disorder:_____ Stomach/ulcer disease:_____

Diabetes:_____ Thyroid problems:_____ Kidney/urinary disease:_____

Hepatitis:_____ Blood clots, leg/lungs:_____ Seizure/neurological disorder:_____

Current medications

Name and dosage (Please continue on back of page if needed)

_____ _____

_____ _____

Social History

Any alcohol use Yes_____ No_____ If yes, how many per occasion?_____

Any tobacco use? Yes_____ No_____ If yes, how many per occasion?_____

Any caffeine use? Yes_____ No_____ If yes, how many per occasion?_____

Any drug use? Yes_____ No_____ If yes, how many per occasion?_____

Surgical History

Year and type of surgery (Please continue on back of page if needed)

_____ _____

_____ _____

Family History (Any female family members, ie, grandmother, mother, aunt, sister)

Breast cancer:_____ Cervical cancer:_____ Ovarian cancer:_____ Uterine cancer:_____

Colon cancer:_____

Do you have an "Advanced Directive? Yes_____ No_____ If yes, what type:?_____