

**Please complete both sides of form.**

# OB-GYN ASSOCIATES OF NORTHERN INDIANA, P.C.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

## **INITIAL PATIENT SELF-HISTORY FORM**

Provide all information requested to the best of your ability.

**ALLERGIES** (Include medications, Latex, Iodine)

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## **GYNECOLOGIC HISTORY**

Age at first menses (period) \_\_\_\_\_ Age at menopause (if applicable) \_\_\_\_\_

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period \_\_\_\_\_ Period interval (1<sup>st</sup> day to 1<sup>st</sup> day) \_\_\_\_\_ days

How many days are: Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light \_\_\_\_\_

Have you ever had an abnormal pap smear? \_\_\_\_\_

If yes, how was it treated? \_\_\_\_\_ When? \_\_\_\_\_

Date of last pap smear \_\_\_\_\_ Have you had a mammogram? \_\_\_\_\_ When? \_\_\_\_\_ Result \_\_\_\_\_

Types of birth control used, including vasectomy \_\_\_\_\_

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

If yes, what kind? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? \_\_\_\_\_

## **PREGNANCY HISTORY**

# of full-term deliveries \_\_\_\_\_ # of premature deliveries \_\_\_\_\_ # of miscarriages \_\_\_\_\_ Was surgery needed? \_\_\_\_\_

# of abortions \_\_\_\_\_ Any complications? \_\_\_\_\_ Any "tubal" pregnancies? \_\_\_\_\_ When? \_\_\_\_\_

# of vaginal deliveries \_\_\_\_\_ # of Cesarean sections \_\_\_\_\_ Years of deliveries \_\_\_\_\_

Any serious complications during your pregnancies or deliveries? \_\_\_\_\_

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## **RISK FACTORS**

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? \_\_\_\_\_ If yes, last used? \_\_\_\_\_ Any needles? \_\_\_\_\_

Age at first intercourse \_\_\_\_\_ Total # of sexual partners \_\_\_\_\_ Total # of sexual partners in last year \_\_\_\_\_

Have you had any sexually transmitted infections? \_\_\_\_\_ If yes, what? \_\_\_\_\_ When? \_\_\_\_\_

Do you believe yourself to be at risk of exposure to the AIDS virus? \_\_\_\_\_

**Please complete both sides of form.**

**SURGERY** (Other than gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOSPITALIZATIONS** (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT
_____	_____	_____	_____
_____	_____	_____	_____

**PAST AND PRESENT MEDICAL PROBLEMS**

<input type="checkbox"/> Abnormal PAP, h/o	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypercoagulable disorder	<input type="checkbox"/> Preterm delivery, prior
<input type="checkbox"/> Anemia	<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Psychiatric disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Drug/alcohol use	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Recurrent miscarriages
<input type="checkbox"/> Bartholin's gland cyst	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Infertility	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Blood transfusion, h/o	<input type="checkbox"/> Family hx of genetic disorder	<input type="checkbox"/> Neonatal death, prior	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Fetal death, prior	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast mass	<input type="checkbox"/> Fibroid uterus	<input type="checkbox"/> Obesity	<input type="checkbox"/> Uterine cancer
<input type="checkbox"/> Bruising / bleeding disorder	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> UTI, h/o recurrent
<input type="checkbox"/> Cerebrovascular accident	<input type="checkbox"/> Genital herpes, exposure	<input type="checkbox"/> Ovarian cyst	<input type="checkbox"/> Vaginal infections, recurrent
<input type="checkbox"/> Cervical cancer	<input type="checkbox"/> Genital herpes, h/o	<input type="checkbox"/> PID	<input type="checkbox"/> STD
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Polycystic ovary syndrome	
<input type="checkbox"/> Coronary heart disease	<input type="checkbox"/> Hemoglobinopathy	<input type="checkbox"/> Prolapsed uterus	
<input type="checkbox"/> Cystocele	<input type="checkbox"/> Hepatitis/Liver disease	<input type="checkbox"/> Premature rupture of membranes	

Other Medical/Surgery History not listed \_\_\_\_\_

**FAMILY HISTORY** Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.

Diagnosis

◀ ↙ Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.

Alive and Well <input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Alcoholism	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Downs syndrome	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Asthma	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hemophilia-A	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Autoimmune disorder	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hyperlipidemia	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Breast cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Hypertension	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cervical cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Mental illness	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Coagulopathy	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Mental retardation	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Colon cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Muscular dystrophy	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Coronary artery disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Ovarian cancer	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cerebrovascular accident	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Seizure disorder	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Cystic fibrosis	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Sickle cell disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Depression	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Spina bifida	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
Developmental delay	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>	Thyroid disease	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>
		Other <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/>

Other Family History not listed \_\_\_\_\_

Check if adopted/family history not known