ObGyn of East Brunswick
By Women For Women
an Axia Women's Health Care Center

172 Summerhill Rd
East Brunswick, NJ 08816
P/ (732) 254-1500
www.obgyneb.com

COMPREHENSIVE HEALTH HISTORY

NAME_____ AGE_____ DATE_____

REASON FOR VISIT_____MARITAL STATUS S M W D

MEDICAL HISTORY	Y	N	EXPLAIN	PHYSICIAN NOTES
1.Eye, ear, nose, throat, problems				
2.Respiratory: asthma, tuberculosis, other				
3.Cardiac: heart disease, murmur, high blood pressure, other				
4.Breast: prior surgery, pain, do you feel a lump?, mammography			Date of last mammography_____	
5.GI: ulcers, colitis, other				
6.Neurologic: seizures, migraines, other				
7.Urinary: bladder infections, kidney problems, urine leakage, other				
8.Musculoskeletal: arthritis, fractures, other				
9.Endocrine: diabetes, thyroid, other				
10.Blood disorder: anemia, varicose veins, sickle cell, blood clots, other Have you ever had a transfusion?				
11.Skin disease				

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12.Psychiatric disorders: counseling, hospitalization, medications			When_____	

NAME_____

13.Surgical procedures Date

_____

_____

_____

14.Medications/Vitamins/Supplements

_____

_____

_____

15.Drug Allergies Reaction

_____

_____

16.Social History: Alcohol _____ drinks/weeks Caffeine _____ups/day Dairy ____ servings/day

Cigarettes: _____ day Street Drugs: Yes No Past Sexual Abuse: Yes No Exercise: _____days/week

Have you been involved in trauma/violence: Yes No
Do you wear seat belts Always Sometimes Never

Serious Accidents Yes No Describe _____

17.Immunizations:
Gardasil - Yes No Year_____ Flu - Yes No Year _____
Hepatitis B - Yes No Year _____ DTAP - Yes No Year _____ Pneumonia - Yes No Year _____ Tetanus - Yes No Year _____ Rubella - Yes No Year _____
Chicken Pox - Yes No Year _____

18.Obstetric History:
Total Pregnancies_____ Term____ Premature____ Miscarriages____ Abortions ____

Date MO/YR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	HOSPITAL OF DELIVERY	WEIGHT GAIN	COMMENT/COMPLICATIONS

Name_____

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19.Family History:

	LIVING		DECEASED	
	AGE	HEALTH	AGE	CAUSE
MOTHER				
FATHER				
BRO/SIS				
BRO/SIS				
BRO/SIS				
BRO/SIS				

Any Family History:

Breast cancer_____ Ovarian cancer_____ Heart disease _____
Diabetes_____ Colon cancer_____ Osteoporosis _____
High blood pressure_____ High Cholesterol_____

20.Gynecological History:

Do you desire future pregnancy? Yes No When_____
Have you had Rubella? (German measles) Yes No DES exposure Yes No
Current birth control_____

Mentrual History
Last menstrual period_____
Are your periods regular Yes No
# of days bleeding_____ Every_____days
Bleeding between periods Yes No
Bleeding after sex Yes No Pain
with periods Yes No
Age of first period_____

PAP History
Last PAP_____ Normal Abnormal
Have you ever had an abnormal PAP? Yes No
Results _____
Treatment_____

Sexual History
Are you currently sexually active Yes No
Have you ever had:
Herpes Yes No
Chlamydia Yes No
Genital warts Yes No
Gonorrhea Yes No
Trichomoniasis Yes No
Pelvic inflammatory disease Yes No
Are you having sexual problems Yes No

General History
Do you have vaginal discharge Yes No
Describe _____
Have you ever had:
Fibroids Yes No
Endometriosis Yes No
Ovarian cysts Yes No
Other _____

partners: Lifetime total_____ Current_____ Male_____ Female_____ Both_____

Menopause History
Are you post-menopausal Yes No
Age last period_____
Symptoms_____
Are you on hormones Yes No
Interested in hormones Yes No