OB/GYN- Scott C. Wyman MD

Family and personal health history

Please complete the following information as accurate as possible. If you cannot remember specific details, please give the best estimate. Thank you.

Name:	**DOB:**	**Date:**

Gynecologic History:

Problems with Menstrual Periods?___No ___Yes **Details:** _____

Frequency? (26 days? 28 days?)_____**Date of Last Menstrual Period**_______________

Age of First Period? _____ Date of Positive Pregnancy Test _______________

Date of Last Pap____________
History of Abnormal Pap?___No ___Yes **Details:**

History of Breast Disease?___No ___Yes **Details:**

What is your current method of Contraception?___None___Birth Control Pill___IUD ___Other

Sterilization___No___Yes **Details:**

History of Endrometriosis?___No___Yes **What treatments?**

History of Infertility?____No____Yes **What tests and/or treatments?**

History of Sexually Transmitted Disease?___No ___Chlamydia___Herpes GenitalWarts (HPV) ___Gonorrhea___Other:

History of AlcoholAbuse?___No___Yes **If yes, details:**

Obstetric History-(Please include miscarriage/abortion history)

Year	City/State	Pregnancy Duration	Hours in Labor	Sex	Birth Weight	Type of Delivery	Complications

Surgical History and Hospitalizations

Year	City/State	Type of Surgery/Reason for Hospitalization	Complications

Health Maintenance

Cholesterol Screening: ___No___Yes
Results: **Date:**
Mammogram:___No___Yes
Results:Date:
Colonoscopy:___No___Yes
Results:Date:
Bone Density Scan:___No___Yes
Results:Date:
Tobacco Use:___No___Yes **Packs per day_____Quit?_____Date_______________**
Alcohol Use:____No___Yes **Drinks per week_____**
Exercise:____Never____1-3 times a week____2-4 times a month
Vitamins and/or Calcium Supplements:___No___Yes
Recreational Drug Use:___No___Yes **Have you used or shared needles?**___No___Yes

Current Medications **No Medications _____**

Medications	Dosage	Frequency	Prescribing Physician

Medical Allergies **No Known Allergies _____**

Medication	Reaction

Personal & Family History: (self, family member, and any details you can remember)

***Are you Adopted? ___No ___Yes**

History	Family If yes, who?	Self	Details
High Blood Pressure or Vascular Disease (High Cholesterol, Varicose Veins, Blood Clots in Legs)			
Heart Disease (Irregular beats, Heart Attack, Valve Issues, etc.)			
Pulmonary Disease (Asthma, Emphysema ,COPD, TB)			
Diabetes (Type 1 or Type 2, Insulin treatment)			
Thyroid Disease (Underactive, Overactive, Goiters, Graves Disease,)			
Gastrointestinal Disease (Hepatitis, Gallbladder problems, Acid Reflux, Crohns ..)			
Kidney and Bladder Problems (Infections, Stones, Bladder Control Problems)			
Neurological Problems (Migraines, Seizures, Strokes, Paralysis)			
Hematologic (Blood**) Disease** (Anemia, Leukemia, Clotting Problems)			
Musculoskeletal Problems (Arthritis, Joint or Spine problems, Osteoporosis)			
Emotional or Psychiatric Problems (PMS, Anxiety, Depression, Bipolar, Suicide)			
Female Cancers (Breast, Cervix, Uterus, Ovaries)			
Other Cancers (Colon, Lungs, Prostate)			
Genetic (inherited**) or Congenital Diseases** (Down Syndrome, Cystic Fibrosis, Hemophilia)			
Other Autoimmune disease such as lupus etc.)			

HAVE YOU HAD ANY GENETIC SCREENING OR DIAGNOSIS OF:

	Yes	No		Yes	No
Age Over 35			**Muscular Dystrophy**		
Thalassemia (Italian, Greek, Mediterranean, Or Asian Background)			**Cystic Fibrosis**		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Amemcephaly)			**Huntington Chorea**		
Congenital Heart Defect			**Mental Retardation/Autism** (if yes was person for Fragile X)		
Down Syndrome			**Other Inherited Genetic or Chromosomal Disorder**		
Tay-Sachs (EG, Jewish, Cajun, French Canadian)			**Maternal Metabolic Disorder** (E.G. Insulin-Dependent Diabetes, PKU)		
Sickle cell Disease or Trait(African)			**Patient or Baby's Father had a Child with Birth Defects** (Not Listed)		
Hemophilia			**Recurrent Pregnancy Loss, or a Stillbirth**		

Personal History

	Yes	No		Yes	No
History of Domestic Violence			**Perpetrator Name:**		
Perpetrator in the Home			**Restraining Order in Place**		

Sexual Practices

	Yes	No		
Sexually Active			**Orientation Homo, Hetero, or Bi-Sexual**	
Practice Safe Sex			**Number of Current Partners**	
Other:			**Number of Partners you have been within your lifetime**	
			Gender Identity	