6301 University Commons, Ste 310
South Bend, IN 46635

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)

_____

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 (1st day to 1st 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? _____

_____

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

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

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.		Diagnosis		
Alive and Well ☐			Diabetes	○ Yes ○ No	
Alcoholism	○ Yes ○ No		Downs syndrome	○ Yes ○ No	
Asthma	○ Yes ○ No		Hemophilia-A	○ Yes ○ No	
Autoimmune disorder	○ Yes ○ No		Hyperlipidemia	○ Yes ○ No	
Breast cancer	○ Yes ○ No		Hypertension	○ Yes ○ No	
Cervical cancer	○ Yes ○ No		Mental illness	○ Yes ○ No	
Coagulopathy	○ Yes ○ No		Mental retardation	○ Yes ○ No	
Colon cancer	○ Yes ○ No		Muscular dystrophy	○ Yes ○ No	
Coronary artery disease	○ Yes ○ No		Ovarian cancer	○ Yes ○ No	
Cerebrovascular accident	○ Yes ○ No		Seizure disorder	○ Yes ○ No	
Cystic fibrosis	○ Yes ○ No		Sickle cell disease	○ Yes ○ No	
Depression	○ Yes ○ No		Spina bifida	○ Yes ○ No	
Developmental delay	○ Yes ○ No		Thyroid disease	○ Yes ○ No	
			Other	○ Yes ○ No	

Other Family History not listed_____

_____

Check if adopted/family history not known ☐