K. Anthony Shanbour, M.D.
Obstetrics & Gynecology

Patient History Form

A

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: ____
3. Referring Physician: ____
4. Occupation:____
5. Preferred phone number: ____________________ confidential voice mails OK: Yes No

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B MENSTRUAL HISTORY(complete even if post-menopausal or no longer having periods)

7. Age at first period: _______ years.
8. If your menstrual periods are regular; periods start every: ___________ days
9. If your menstrual periods are irregular; periods start every:____ to ____ days (e.g.,12 to 60)
10. Duration of bleeding: _____ days
11. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
12. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
13. First day of last menstrual period______________________________(month/day/year)
14. Is pain associated with periods? ☐ Yes ☐ No ☐Occasionally
15. If yes to 14, is it: ☐ before menses? ☐ during menses? ☐ both?

C PREGNANCY HISTORY (All pregnancies) **Have never been pregnant** ☐

16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

					CHILD		
Year	Place of delivery or Abortion	Duration Preg.	Type of Delivery	Complications Mother and/or Infant	Sex	Birth Weight	Present Health

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D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use? _____________________________

E SEXUAL HISTORY

18. Do you have a sexual partner? ☐ No ☐ Yes (Male Female)

19. Are there concerns about your sexual activity which you want to discuss? ☐Yes ☐No

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F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ ovarian surgery	
☐ hysteroscopy		☐ L cyst(s) removed	
ovarian			
☐ infertility surgery		☐ R cyst(s) removed	
ovarian			
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ vaginal or bladder repair	
☐ hysterectomy (vaginal)		for	
prolapse/incontinence			

☐ hysterectomy (abdominal) ☐ cesarean section

☐ myomectomy ☐ other (specify)

____

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or ☐ None

Surgeries	Year
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

H PAP SMEAR/MAMMOGRAM HISTORY

22. ☐Date of last pap smear: ______________________

23. ☐Have you had abnormal pap smears? ☐ No ☐Yes

24. ☐Have you had treatment for abnormal smears? ☐ No ☐Yes

If yes, what type(s) of treatment have you had?

☐ cryotherapy ☐ laser ☐ cone biopsy ☐loop excision (LEEP)

25. Date of last mammogram: ________ ________

month **year**

26. Have you had an abnormal mammogram? ☐ No ☐Yes

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: ☐None ☐ Venereal warts ☐Herpes-genital ☐Shpilis
☐Pelvic inflammatory disease ☐Endometriosis ☐Chlamydia ☐Gonorrhea
☐Vaginal infections ☐ Other ______________________________________

I PAST MEDICAL HISTORY Check any that apply: or None

☐ Arthritis
☐ Diabetes:
- ☐ Diet controlled
- ☐ Pill controlled
- ☐ Insulin controlled

☐ High blood pressure
☐ Heart disease
☐ Kidney Disease

☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease

☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other:__________

J PAST MEDICAL HISTORY Check any that apply: or None

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No ☐ Yes☐ ________packs/day

29. Use alcohol ☐No ☐Yes __ wine (glass/day); __ beer (bottle/day); __ hard liquid(oz./day)
30. Use illicit drugs No ☐ Yes ☐ ______________type _______________amount
31. Exercise: Type:_____________________ How often_____________________

L DRUG ALLERGIES

32. No ☐ Yes ☐ List:

____
____
____

M FAMILY HISTORY

☐Diabetes ☐Heart Disease ☐Breast Cancer ☐Other

☐Ovarian Cancer ☐Endometrial Cancer ☐Colon Cancer ____________________

If "yes" to any, please list affected relatives

_______________________________________ _______________________________________
_______________________________________ _______________________________________

☐ **None of the above.**

N OTHER SYMPTOMS

Have you had recent?

☐ weight loss ☐hair growth ☐none of the above

☐ weight gain ☐hair loss ☐other

☐change in energy ☐change in urinary function ____________________

☐breast discharge ☐hot flushes/flashing

____ _____________ _____________
Patient Signature Date Time

____
Patient Name Printed