Fair Oaks Women's Health
Obstetrics and Gynecology
625 South Fair Oaks Avenue
Suite 255, South Lobby
Pasadena, CA 91105

Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

www.fowh.com
obgyn@fowh.com
Voicemail 626.696.2688
Facsimile 626.585.0695
Telephone 626.304.2626

NEW GYN PATIENT HISTORY FORM
(OB PATIENTS, please DO NOT USE THIS FORM. Thanks.)

TODAY'S DATE ______________________________ Your age_________ DATE OF BIRTH ________________________________

YOUR NAME (Last) ____ (First)_______________________ (M.I.) _________

REFERRED HERE BY ____

YOUR PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X or a √)
Thank you for answering all of the following questions. Your health is important to us.

Breast Conditions
_____ Recent Mammogram When? _____________
_____ History of Abnormal Mammogram
_____ Breast Cancer
_____ Breast Implants
_____ Fibrocystic Breast
_____ Other ____________________________________

Gyn Conditions
_____ Abnormal Pap Smear
_____ Endometriosis
_____ Fibroids
_____ Herpes (circle which type- oral and/or genital)
_____ HPV (Human Papilloma Virus)
_____ Menopause
_____ Ovarian Cysts or PCOS (polycystic ovary)
_____ Severe PMS
_____ Other ____________________________________

Heart or Circulation Conditions (Cardiovascular)
_____ Blood Clot (DVT or Pulmonary Embolism)
_____ Fainting (Syncope)
_____ High Blood Pressure
_____ Varicose Veins
_____ Other ____________________________________

Endocrine (Glandular) Disorders
_____ Diabetes (circle which type: Type 1 or Type 2)
_____ Pituitary Gland Disease
_____ Thyroid Disease
_____ Other ____________________________________

Immune System Diseases
_____ Lupus or Rheumatoid Arthritis
_____ Other ____________________________________

Gastrointestinal (GI) Problems
____ Blood in Stool
____ Crohn's Disease or Ulcerative Colitis
____ Hemorrhoids
____ Hepatitis
____ Irritable Bowel Syndrome
____ Had Colonoscopy? When? ________________
____ Other ____________________________________

Blood (Hematologic) Disorders
____ Anemia
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other ____________________________________

Musculoskeletal Disorders
____ Fractures or Broken Bones
____ Arthritis or Joint Pain
____ Severe Back Pain or Back Disease
____ Other ____________________________________

Neurologic Disorders
____ Migraines or Severe Headaches
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other ____________________________________

Mental Health Conditions
____ Bipolar (Manic-Depressive)
____ Nervous Breakdown
____ OCD (Obsessive-Compulsive)
____ Severe Anxiety or Panic Attacks
____ Severe Depression or Postpartum Depression
____ Other ____________________________________

Respiratory (Lung) or ENT Disorders

____ Allergies, Hay Fever
____ Asthma
____ Bronchitis/Pneumonia
____ Lung Cancer
____ Sinusitis or Sinus Problems
____ Sleep Apnea
____ Other ____________________________

Urinary (Urological) Disorders

____ Frequent Bladder Infections
____ Kidney Stones or Other Problems
____ Other ____________________________

Skin Conditions

____ Acne (severe)
____ Eczema
____ Excess Hair Growth
____ Hives
____ Psoriasis
____ Other ____________________________

What is your height? ____________________

What is your recent weight?______________

REVIEW OF SYSTEMS – RECENT ABNORMAL SYMPTOMS

(Are you currently experiencing any of the following symptoms to a significant degree?)
(If so, please indicate with an X or a √)

General

____ Fatigue or Weakness
____ Fever, Chills or Sweats
____ Unexplained weight gain or loss

Skin

____ Lesions, Moles or Sores
____ Rash

Eyes, Ears, Nose and Throat

____ Sore Throat
____ Trouble Swallowing
____ Vision or Hearing Changes
____ Nose Bleeds

Breasts

____ Breast Lump or Lumps
____ Breast Pain or Tenderness
____ Nipple Discharge (other than white)

Cardiovascular

____ Chest Pain or Tightness
____ Irregular Heartbeat or Palpitations

Respiratory

____ Chronic Coughing
____ Shortness of Breath or Wheezing

Gastrointestinal

____ Heartburn
____ Nausea or Vomiting
____ Diarrhea (watery stool)
____ Severe Constipation
____ Abdominal Pain
____ Rectal Bleeding

Urinary

____ Burning with Urination
____ Urgency and/or Frequency of Urination
____ Leakage of Urine
____ Waking at night 2 or more times to urinate

Gyn (also see Menstrual History ahead)

____ Genital sores, lesions or bumps
____ Irregular periods
____ Bleeding Between Periods
____ Pain Before or During Periods
____ Vaginal Itching, Burning or Dryness
____ Vaginal Discharge
____ Vaginal Dryness
____ Pain during intercourse
____ Vulvar Pain
____ Severe PMS Symptoms

Endocrine (Glandular)

____ Menopause Symptoms (hot flashes)
____ Intolerance to Heat or Cold
____ Low Sex Drive
____ Excessive Hair Loss
____ Excessive Hair Growth

Musculoskeletal

____ Joint Pain (Back, Knee, Wrist, Hip)
____ Joint Swelling
____ Muscle Cramping or Pain

Hematologic

____ Swollen Glands
____ Easy/Frequent Bruising

Neurologic

____ Dizziness
____ Headaches
____ Numbness
____ Memory Problems

Psychiatric

____ Excessive Anxiety, Worries, Stress
____ Severely Depressed
____ Insomnia

Patient Name ____________________________________

PAST SURGERY or HOSPITAL ADMISSIONS

List all Surgeries or Hospital Admissions - EVER	Year

CURRENT PRESCRIPTION MEDICATIONS YOU ARE TAKING

Medication name, dosage (amount) and reason (include meds "as needed")
Recent Vaccines (Please enter here):

PHARMACY INFO (so we can E-prescribe for you)

Pharmacy Name: ____ Phone # _______________________

Pharmacy Address: ____ Fax # __________________________

Do we have permission to import your medication history using our electronic prescription software? YES NO

VITAMINS, HERBS AND SUPPLEMENTS YOU ARE TAKING

Product name and how often (include dosage if known)

ALLERGIES (circle choices)

If yes, please list all allergies and your allergic reaction

Do you have ANY allergies? NO ALLERGIES Allergic to Latex? YES NO

Allergic to	**Reaction**

Patient Name ___________________________________

FAMILY MEDICAL HISTORY

FOR THE ITEMS BELOW, PLEASE CONSIDER the following relatives: *(Yourself, Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, and Nephews).* This is a screening method to see if you are at increased risk for having a genetic mutation that can cause hereditary cancer.

CANCER RISK ASSESSMENT			Please Answer Yes or No, indicate age, and who has that specific condition.
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Breast Cancer**?	
Y	N	Have **YOU** or a **Family Member** ever been diagnosed with **Colon Cancer or Endometrial Cancer**?	
Y	N	Have **YOU** or a **Family Member** had ten or more lifetime colon polyps (colorectal adenomas)?	
Y	N	Are **YOU** of Jewish ancestry *with* **Breast Cancer** in any **Family Member**?	
Y	N	Have **YOU or ANY FAMILY MEMBER** been diagnosed with **Ovarian Cancer** at any age?	
Y	N	Do you have **3 or more Family Members** with any of the below cancers on the same side of the family diagnosed at any age? ***Cancers: Breast, Colon, Endometrial (Uterine)***	
Y	N	Are there any **Men** in your family that have been diagnosed with **Breast Cancer**?	

OTHER CONDITIONS	Please CIRCLE CONDITION (on the left) and indicate below who has that specific condition.
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE	
2. HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE	
3. ASTHMA or OTHER LUNG DISEASE	
4. KIDNEY DISEASE or KIDNEY STONES	
5. GI or LIVER PROBLEMS, LIVER TUMORS OR CANCER, IBS, COLITIS	
6. GYN DISEASES, OVARIAN, CERVICAL OR UTERINE CANCER, UTERINE FIBROIDS	
7. MUSCULOSKELETAL DISEASES, OSTEOPOROSIS or OSTEOPENIA	
8. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES	
9. SEVERE DEPRESSION or OTHER MENTAL HEALTH CONDITION	
10. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND	
11. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE	
12. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT	

Comments:

____

Patient Name ___________________________________

SOCIAL HISTORY

Level of Education: ______________________ Employment/Occupation: ______________________

Type of Diet: ______________________ Type of Exercise: ____________________ How Often? ____________________

Seat Belts Routine: ___YES ___NO Sunscreen Routine ___YES ___NO

Smoking (Vaping?) History: NONE or ____

Alcohol Intake: NONE or ____

Drug Use: NONE or ____

General Life Stress: ___LOW ___MED ___HIGH Sexually Active: ___YES ___NO If yes, condoms used? __________

In a Relationship?: ___YES ___NO ___OTHER Members of Household: ______________________________

MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD ______________________ *CYCLE LENGTH (28 days or ?) ____________________

# of DAYS of BLEEDING during a *PERIOD ____________ # days heavy______________ # days light/spotting ______________

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) ______________________________

BIRTH CONTROL METHOD ______________________ If none, please enter reason ______________________

LAST Pap Smear (MM/YY) ______________________________By who? ______________________________

(***period** means # of bleeding days; **cycle length** means total # of bleeding & non-bleeding days starting with a period)

PREGNANCY SUMMARY (how many…?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: ____

____

PREGNANCY DETAILS

Child's Birthdate	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location