



El Camino Women's Medical Group

Obstetrics, Gynecology, Infertility & Minimally Invasive Surgery

Medical history

General information:

Name:

DOB:

Age:

Primary doctor:

Past medical history:

Please list all allergies and your reaction:

☐

None

Please list all medications, including birth control, supplements, herbs, vitamins, and over-the-counter drugs:

☐

None

Please list any medical conditions, including mental health conditions:

☐

None

Please list all major injuries, surgeries, and/or hospitalizations you have had:

☐

None

Date of last physical exam:

Date of last mammogram:

Date of last colonoscopy:

Family history:

Please list any medical problems affecting close relatives, including cancer:

Father:

Paternal uncle:

Mother:

Paternal aunt:

Paternal grandfather:

Maternal uncle:

Paternal grandmother:

Maternal aunt:

Maternal grandfather:

Siblings:

Maternal grandmother:

Children:

Spouse:



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Social History:

Do you use tobacco products? ☐ No Used to, but quit ☐ Yes

If yes, how many per day?

And for how many years?

Do you drink alcohol?

If so, how often?

Do you use recreational or illegal drugs?

How many servings of dairy products do you eat in an average day?

How many times a week do you exercise?

What activities?

Do you have pets?

With whom do you live?

Has anyone threatened or hurt you in the last year?

What is your occupation?

Past gynecological history:

At what age did you experience your first menstrual period?

How often is it and for how many days?

If menopausal, when was your last period?

Date of last Pap smear:

Have you ever had an abnormal Pap smear?

If so, what date was the most recent abnormal pap?

How old were you the first time you engaged in sexual intercourse?

How many sexual partners have you had in your life? _____ Male _____ Female

Are you currently sexually active? If so, how long have you been with your current partner?

Have you ever had a sexually transmitted infection?

If so, what kind and when?

Do you have concerns about your sex life that you wish to discuss?

Do you experience urinary leakage?

Have you ever been told you have fibroids or ovarian cysts?

Past obstetrical history:

Number of pregnancies:

Number of term births:

Number of preterm births:

Number of miscarriages:

Number of abortions:

Number of living children:

For each pregnancy:

Date of delivery	Weight of baby	Gender	Type of delivery	Epidural?	Complications?