PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Drug Name	Dosage	Physician

List Any Allergies to Medications/Substances (latex gloves, etc.): _____

_____

_____

YOUR GYN HISTORY

Were you using any birth control when you got pregnant? ❒ Yes ❒ No

❒ Condoms
❒ Depo Provera
❒ Diaphragm
❒ IUD: Kind _____
Date Inserted _____
❒ Birth Control Pill
Name of Pill _____
❒ Contraceptive Foam/Jelly
❒ Nuvaring
❒ Birth Control Patch
❒ None
❒ Natural Family Plan/Rhythm
❒ Tubal Ligation
❒ Vasectomy
❒ Withdrawal
❒ Other: _____

What age did you have your first period? _____

How many days are there from the start of your period to the start of your next period? _____ days

How long does your period last? _____ days Flow: ❒ Light ❒ Medium ❒ Heavy

What number of tampons or pads are used in a day?_____

Do you pass clots? ❒ Yes ❒ No

Date of last period:_____Are you sure of the date? ❒ Yes ❒ No

Was it a normal period? ❒ Yes ❒ No

Have you had a home urine pregnancy test? ❒ Yes ❒ No When: _____

Have you had an office urine pregnancy test? ❒ Yes ❒ No When: _____

Have you had an office blood pregnancy test? ❒ Yes ❒ No When: _____

Have you had recent abnormal bleeding? ❒ Yes ❒ No When: _____

IF YOU HAVE STOPPED HAVING PERIODS, PLEASE ANSWER THE QUESTIONS BELOW:

Age of Menopause_____ Do you take prescription hormones now? ❒ Yes ❒ No

Did you take hormones in the past? ❒ Yes ❒ No Do you take herbal hormones? ❒ Yes ❒ No

YOUR OB HISTORY

	Number		*Number*
Total Number of Pregnancies		Full Term Births	
Premature Delivery (less than 37 weeks)		Abortions/Termination	
Miscarriages		Living Children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks. Gest.	Labor (hrs.)	Baby's Weight/Sex	Del. Type Vag/Csection	Epid Y/N	Preterm Labor?	Wt. Gain	Comments/ Complications	Hospital
1				❒M ❒F						
2				❒M ❒F						
3				❒M ❒F						
4				❒M ❒F						