CONCORD OB/GYN Medical History

Date: _____

Legal Name: _____ Chosen Name: _____ Date of Birth: _____

Preferred Pronouns (circle): she/her he/him they/them other: _____

Gender Identity: female ☐ non-binary ☐ transgender male ☐ other: _____

Primary Care Provider: _____ Pharmacy: _____

What is the reason for your visit today? _____

Gynecological History

Have you ever been vaccinated for HPV- Gardasil_____ Yes ☐ No ☐
Last PAP Smear_____
Last Mammogram_____
Last Bone Density (DEXA) _____
Last Colonoscopy_____
Have you ever been on hormone replacement therapy (HRT)? _____ Yes ☐ No ☐
Any personal history of:
Abnormal Pap Smear_____ Yes ☐ No ☐
Have you ever had a sexually transmitted disease? _____ Yes ☐ No ☐
If yes, which one(s)? HPV ☐ Chlamydia ☐ Gonorrhea ☐ HSV ☐ HIV ☐
Syphilis ☐ Trichomoniasis ☐ Hepatitis ☐
Fibroids_____ Yes ☐ No ☐
Endometriosis_____ Yes ☐ No ☐
Infertility_____ Yes ☐ No ☐
Urinary Incontinence_____ Yes ☐ No ☐

Menstrual History

First day of last menstrual period _____
Age at first menstrual period _____
Number of days between periods _____
Number of days that you bleed _____
Describe the menstrual flow _____ light/moderate/heavy/clots
Describe the amount of menstrual discomfort _____ none/mild/moderate/severe
Do you bleed in between your periods? _____ Yes ☐ No ☐
Do you bleed after intercourse? _____ Yes ☐ No ☐
If you stopped menstruating, at which age did you stop? _____
Have you had bleeding or spotting since your period stopped? _____ Yes ☐ No ☐

Contraceptive and Sexual History

Present contraception method _____
Contraception methods used in the past (list): _____
Have you ever been sexually active? _____ Yes ☐ No ☐
What is your sexual orientation? heterosexual/straight ☐ homosexual ☐ bisexual ☐ asexual ☐ other: _____
What is/are the gender(s) of your current sexual partner(s)? _____
Do you experience pain or discomfort with sexual intercourse? _____ Yes ☐ No ☐
Would you like to discuss sexual activity or birth control today? _____ Yes ☐ No ☐

Obstetrical History

Pregnancies _____ Living Children _____ Vaginal Births _____ C-Sections _____
Miscarriages _____ Abortions _____ Ectopic Pregnancies _____
List any complications of pregnancy or delivery _____

Medical History

Have you or a family member had the following? Please describe.

	YOU	Family Member
Genetic Disease/Blood Clotting Disorders	_____	_____
Heart Disease	_____	_____
Hypertension	_____	_____
Thyroid Condition	_____	_____
Kidney Disease	_____	_____
Diabetes	_____	_____
Hepatitis/Liver Disease	_____	_____
Respiratory Disease	_____	_____
Psychiatric Disease	_____	_____
Breast Cancer	_____	_____
Uterine Cancer	_____	_____
Ovarian Cancer	_____	_____
Colon Cancer	_____	_____
Stroke/Migraines	_____	_____
Other major illness/ medical problems	_____	_____

Surgical History

Have you ever had surgery? Yes ☐ No ☐ If so, what kind? _____
Have you or family members had difficulty with anesthesia? _____

Personal/Social History

Occupation: _____
Do you exercise? Yes ☐ No ☐ How often? _____
Do/Did you use tobacco or marijuana products? Yes ☐ No ☐ How much? _____
Do/Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? _____
Do/Did you use illicit drugs? Yes ☐ No ☐ which drugs did you use? _____
Have you ever been a victim of physical, verbal, emotional or sexual abuse? _____

Current Medications

Medicine	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (Medication, Food, Environmental)

❑ NO KNOWN ALLERGIES

Allergen	Type of Reaction
_____	_____
_____	_____
_____	_____