***OB-GYN Associates of Ithaca***
***20 Arrowwood Drive, Ithaca, New York 14850***
***607-266-7800***

***Please complete this questionnaire prior to your appointment. If you are a new patient, please complete entire form. If you are an established patient, please update as needed. Thank you!***

| Date: | | | |
|---|---|---|---|
| Name: | Date of birth: | Age: | |
| Reason for visit: | | | |

***Menstrual and sexual history***

| | |
|---|---|
| Last menstrual cycle: | Was it a normal period? Y N |
| If menopausal, age at menopause: | Any menopausal symptoms? |
| Age at first period: | If under 21, age at first sexual intercourse: |
| Number of days between cycles: | Number of days of bleeding: |
| Are you currently sexually active? | If yes, with men, women, or both? |
| Current birth control method: | Any concerns with your birth control? Y N |
| When was your last pap? | Have you ever have an abnormal pap? |
| Have you ever had a colposcopy? | Have you ever had a procedure done to your cervix? |

| | | | | | | |
|---|---|---|---|---|---|---|
| Have you ever had: | | chlamydia | | herpes | | genital warts |
| | | hepatitis | | HIV | | syphilis |
| Have you ever had: | | uterine fibroids | | endometriosis | | ovarian cysts |

***Pregnancy history***

*Please enter all information regarding any previous pregnancies. If you have not been pregnant, skip this section.*

| Date | Delivery location/provider | Sex/Name | Wt | Vaginal/C-section | Complications? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Date | Miscarriage/abortion | Complications |
|---|---|---|
| | | |
| | | |
| | | |

***Medical history***

Primary care provider(s):

Do you have or have you ever had any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | high blood pressure | | heart disease | | high cholesterol | | blood clots |
| | asthma | | tuberculosis | | lung disease | | diabetes |
| | stomach ulcers | | colitis | | gallbladder problems | | liver problems |
| | kidney stones | | kidney disease | | bladder infections | | urinary incontinence |
| | arthritis | | joint problems | | back injury/pain | | broken bones |
| | seizures | | migraine headaches | | numbness/tingling | | breast lump/pain |
| | depression | | mental illness | | alcoholism | | drug use/abuse |
| | skin cancer | | abnormal moles | | eczema/psoriasis | | anemia |
| | stroke | | thyroid problems | | hepatitis | | autoimmune problems |
| | osteoporosis | | cancer | | anxiety | | blood transfusion |

Please list any surgeries you have had in the past:

| Date | Type of surgery | Reason for surgery | Any complications? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Name: Date of birth:

List any medications you ar currently taking, including vitamins or minerals:

List any allergies you may have to medications:

Any latex allergy or sensitivity? Y N

**_Family history_**

*Please list any health conditions that pertain to each biological family member. Please include if they are deceased and what caused their death. If no health problems, state "healthy". If no change from your previous visit, please state "no change".*

Brothers/sisters: Sons/daughters:

Mother: Father:

Maternal grandmother: Paternal grandmother:

Maternal grandfather: Paternal grandfather:

Other maternal family members: Other paternal family members:

Any other significant family history?

**_Social history_**

| Marital/relationship status: | With whom do you live? |
|---|---|
| Highest educational level: | Your occupation: |

| | | | |
|---|---|---|---|
| Tobacco use? Y N | How much per day? | # years use: | |
| Alcohol use? Y N | How much per day/week? | | |
| Drug use? Y N | What substances? | How much per day/week? | |
| Caffeine use? Y N | How much per day/week? | Coffee Tea | Soda/soft drinks |

| | |
|---|---|
| Do you exercise? | If yes, how many times per week? |
| Do you follow any specific diet? | If yes, what type of diet? |
| Do you take a multivitamin? | Do you eat/drink dairy products? |

| | | |
|---|---|---|
| Do you have any concerns regarding your relationship and/or your safety? | Y | N |
| Have you ever been punched, kicked, hit, threatened, or forced to have intercourse? | Y | N |

**_Screening history_**

Have you ever had the following screening tests:

| | | | |
|---|---|---|---|
| Mammogram: | Y | N | If yes, where and when? |
| Colonoscopy: | Y | N | If yes, where and when? |
| Cholesterol tests: | Y | N | If yes, where and when? |
| Diabetes tests: | Y | N | If yes, where and when? |
| Bone density scan: | Y | N | If yes, where and when? |

| Have you received the following vaccinations: | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Tetanus | | Varicella |
| | Hepatitis B | | Influenza | | HPV (Gardasil) | | Rubella |

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