OMAHA OB/GYN ASSOCIATES, P.C.

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Emergencies & After Hours / (402) 932-8020
Medical Record Fax / (402) 905-3041
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FEMALE MEDICAL HISTORY *(Please Complete Before Your Visit)*

Contact Information

Name: _____ Preferred First Name (if different): _____

Phone #: _____ *(cell # may be preferred)* OK to leave a message? _____YES _____NO

Referred by: _____ Preferred Pharmacy: _____

Health Care Providers (✔**CHECK** if you would like a note sent to your health care provider)

___Primary Care: _____ ___Counselor/Therapist: _____

___Gynecologist: _____ ___Physical Therapist: _____

___Counselor/Therapist: _____ ___Psychiatrist: _____

___Other: _____

Demographic Information

Are you (circle all that apply):

Single Married Widowed Committed Relationship Same Sex Relationship

Education:

Less than 12 years High school graduate Currently in school

College Degree Postgraduate degree

What is your profession/what type of work are you doing? _____

Information About Your Condition

What are your primary concerns? _____

_____

How long have you had the issues or concerns? _____

Is there an event associated with the onset of symptoms? ___No ___Yes (explain) _____

_____

What medical/nonmedical treatments have you tried? _____

_____

Medical History

How many pregnancies have you had? _____

Resulting in (#): _____Full 9 months _____Premature _____Miscarriage _____Abortion _____Living children

Age of children: _____

What is your method of birth control? _____ or N/A

Date of last Pap smear: _____ Date of last Mammogram: _____ or N/A

✔**CHECK** all that apply:

____Heavy menstrual flow	____Hysterectomy/no uterus	____Pain with wearing tight pants
____Menstrual cramps	____Removal of 1 ovary	____Pain with tampon insertion
____Irregular periods	____Removal of both ovaries	____Pain with sexual activity
____Last period > 1 year ago	____Endometriosis	____Pain with initial penetration
____Endometrial ablation	____Hot flashes	____Pain with deep penetration
____Pelvic pain	____Night sweats	____Burning vaginal pain after sex
____Recurrent vaginal infections (yeast or bacterial)	____Vaginal itching	____Low/absent sexual desire
____Abnormal Pap smear	____Vaginal discharge	____Difficulty with lubrication
____HPV	____Vaginal tears (paper cut tears)	____Never had an orgasm
____Genital Herpes	____Vaginal dryness	____Delayed ability to orgasm

✔**CHECK** all that apply:

____Fatigue	____Constipation	____Diabetes
____Weight gain	____Diarrhea	____Back pain / Join pain
____Difficulty sleeping	____Irritable bowel syndrome	____Osteoporosis / Osteopenia
____High blood pressure	____Burning with urination	____Migraines
____High cholesterol	____Urinary frequency	____Fibromyalgia
____Blood clot	____Frequent UTIs	____Difficulty focusing
____Heart attack	____Interstitial cystitis	____Irritability
____Stroke	____Leakage of urine	____Attention Deficit Disorder
____Breast tenderness	____Facial hair growth	____Anxiety
____Breast cancer	____Scalp hair thinning	____Depression
Other cancer_____	____Hypothyroid	____Bipolar disorder

Other medical conditions: _____

Health History

**How often do you exercise?* Rarely 1-2 Times weekly 3-5 times weekly Daily

**How many cups of caffeine per day?* (include coffee, tea, soda) 0 1-3 4-6 More than 6

**Do you smoke cigarettes?* NO YES *How many cigarettes per day?* _____ *For how many years?* _____

**How often do you drink alcohol?* Never Rarely Monthly Weekly Daily

**Do you use recreational drugs?* NO YES

**How would you describe your diet?* (circle all that apply)

Well- Balanced Fried/Fast food Low Fat Low Cholesterol Other: _____

**Do you have issues/concerns with your body image or eating habits?* NO YES

**Please list any causes of stress* (ex. finances, work, relationship) _____

**Have you ever been the victim of:* Verbal abuse Physical abuse Sexual abuse Rape No Answer

ALLERGIES: _____

Current Medications

Medication	Dose/Frequency	Notes

Surgical Procedures

Year	Procedure	Year	Procedure

Family History

✔Check if you were you adopted _____ (Leave BLANK If you do not know your family history).

✔Check box if a family member has been diagnosed/treated for any of the following:

	Mom	Dad	Brother	Sister	Grandma (mom's parent)	Grandma (dad's parent)	Grandpa (mom's parent)	Grandpa (dad's parent)
Anxiety								
Depression								
Heart Disease								
High Cholesterol								
Stroke								
Breast cancer								
Ovarian cancer								
Prostate cancer								
Uterine cancer								

Additional comments or conditions not listed above: _____

_____