AN AFFILIATED PRACTICE OF
Yale Medicine

Greater New Haven OB/GYN Group

Today's Date: _____

Date of Birth: _____

Name _____ Preferred Name: _____ Pronouns Used: _____

Age: _____ Occupation: _____ Relationship status: _____

How did you hear about us? ☐ Online Search ☐ Family/Friend ☐ Physician Referral

Reason for visit: ☐ Routine/Well Visit ☐ Problem Visit

Issues you would like to discuss: _____

Current medications _____ ☐ No Medications

_____

Current Supplements/Vitamins: _____

_____

Allergies to medications or food (with reactions, if known): _____ ☐ No Known Allergies

Primary Care Provider (Name and Telephone): _____

When were you last seen by your PCP for a routine visit? _____

GYNECOLOGIC AND SEXUAL HISTORY

When was your last exam with a gynecologist? _____

First day of last period: _____ / _____ /_____ Age or year of last period (if postmenopausal or hysterectomy): _____

Age at first period: _____ # days between periods: _____ # days you bleed: _____

Any problems with your period? _____

Sexually Active: ☐ Yes ☐ Not Currently ☐ Never Monogamous: ☐ Yes ☐ No

Do you have sex with: ☐ Male Partner ☐ Female Partner ☐ FTM Partner ☐ MTF Partner

Current method of birth control: *(check all that apply)*

☐ Birth Control Pills
☐ Withdrawal
☐ Vasectomy
☐ Nexplanon
☐ Natural Family Planning/rhythm
☐ Tubal Ligation
☐ Foam/Spermicide
☐ Vaginal Ring
☐ Diaphragm
☐ Condoms
☐ IUD (type & date of insertion:_____)
☐ DepoProvera Injections

Date and results of last Pap smear: _____

Any history of abnormal Pap smears: ☐ Yes ☐ No If yes, when? _____

Any treatment needed, and if so when? (LEEP/cone biopsy, cryotherapy) _____

Have you had the Gardasil vaccine? (3 doses total) ☐ Yes ☐ No If not, are you interested in receiving it? ☐ Yes ☐ No

Last Mammogram and Result: _____

Last Colonoscopy and Result: _____

Last Bone Density and Result: _____

Please Continue on Other Side

YOUR HEALTH HISTORY

- ☐ Migraine ☐ with Aura
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Breast Problem
- ☐ Kidney Problem
- ☐ Anemia/Blood Disorder
- ☐ Varicose Veins
- ☐ Blood Clot/DVT/PE
- ☐ Autoimmune Disease
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Seizures/Epilepsy
- ☐ Asthma/Lung Problem
- ☐ Jaundice/Hepatitis
- ☐ Bowel Disease
- ☐ Blood Transfusion
- ☐ Depression ☐ Anxiety
- ☐ Pelvic Infection
- ☐ Condyloma (Genital Warts)
- ☐ Herpes ☐ Cold Sores
- ☐ Chlamydia ☐ Gonorrhea
- ☐ Syphilis ☐ HIV
- ☐ DES Exposure
- ☐ Alcohol or Drug Abuse
- ☐ Eating Disorder
- ☐ Other Psychiatric Issues

SURGERIES (with dates)

_____

_____

_____

FAMILY HISTORY: please indicate who was affected and age at diagnosis ☐ ADOPTED

- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Uterine Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Other Cancers
- ☐ Other Health Issues (please list):
- ☐ Hypertension
- ☐ Stroke
- ☐ Blood clot
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Osteoporosis
- ☐ Diabetes

OBSTETRIC HISTORY

Total number (#) of pregnancies_____ # full term _____ # pre-term _____ # miscarriages _____ # abortions _____
ectopic _____ # living children _____ # adopted _____

No	Birth Date (month/yr)	Type of delivery	# weeks of pregnancy	Weight	Sex	Complications
1						
2						
3						
4						
5						

LIFESTYLE

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind of exercise and how often: _____

Do you consider your diet to be healthy? ☐ Yes ☐ No
Do you eat 2-3 servings of calcium daily? ☐ Yes ☐ No
Do you eat at least 4-5 servings of vegetables daily? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No ☐ Quit (Date _____) Chewing tobacco? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No If yes, what substances? _____

How many days a week do you drink alcohol? _____ How many drinks at a time on average? _____

Any other substance use? Specify: _____ How often? _____

Do you feel safe in your current relationship? ☐ Yes ☐ No
Have you been sexually abused, hurt or threatened by anyone? ☐ Yes ☐ No