Stanford HEALTH CARE

Los Olivos Women's Medical Group

**Patient Name**:_____Date:_____

**Allergies and reaction:** _____

**Surgical History:** please add approximate year Age: _____

| | | | |
|---|---|---|---|
| Abdominal Surgery | Year: _____ | Breast Biopsy | Year: _____ |
| Appendectomy | Year: _____ | Hysterectomy | Year: _____ |
| C-Section | Year: _____ | Myomectomy | Year: _____ |
| Heart surgery(CABG) | Year: _____ | D&C for bleeding | Year: _____ |
| Cardiac Catheterization | Year: _____ | Uterine Ablation | Year: _____ |
| Gall bladder surgery | Year: _____ | Tummy tuck | Year: _____ |
| Miscarriage (D&C) | Year: _____ | Breast Implants | Year: _____ |
| Hernia Repair | Year: _____ | LEEP /cone biopsy | Year: _____ |
| Colonoscopy (polyp?) | Year: _____ | Tubal Ligation | Year: _____ |
| Tonsillectomy | Year: _____ | Laparoscopy | Year: _____ |
| Gastric bypass | Year: _____ | | |

Other surgery: _____

## Medical Conditions: Circle all that apply for past or present

Abnormal Uterine Bleeding or Problem with periods
Alzheimer's
HPV or Genital warts
Birth Defects
Cancer
Atrial fibrillation
Aortic Stenosis
Coronary artery disease
Congestive heart failure
High cholesterol
High blood pressure
Heart attack
Uterine cramps
Pain with intercourse
Diabetes treated with insulin
Diabetes treated with pills
Low thyroid
Obesity
Endometriosis
Fecal Incontinence
Uterine Fibroids
Herpes
Hepatitis C
Ulcers or H pylori
Anemia

Pulmonary Embolism
Infertility
Dementia
Seizure Disorder
Osteoporosis
Pelvic Inflammatory disease
Alcohol Abuse
Depression
Asthma
Chronic Obstructive Pulmonary Disease
Obstructive Sleep Apnea
Renal Insufficiency or Kidney Problems
Sexually Transmitted Disease
Sexual Problems
Stroke
Tuberculosis
Urinary Incontinence
Anxiety
Arthritis
Hepatitis B
Irritable Bowel Syndrome
Leukemia
Recurrent Bladder Infections
Polycystic Ovary Syndrome (PCOS)
STD: _____

Other medical conditions: _____

**PLEASE TURN OVER AND COMPLETE BACK PAGE**

## Pregnancy History:

Total number of pregnancies:_____ Total living children: _____
Number of deliveries after 36 weeks (full term):_____ Vaginal: _____ Cesarean: _____
Number of deliveries before 36 weeks (preterm):_____ Vaginal: _____ Cesarean: _____
Number of miscarriages:_____ Number of terminations: _____ Number of ectopic pregnancies:_____

## Social History:

Tobacco Use: Never smoked Current smoker Smokeless Tobacco Use Ready to quit? Yes No
Packs of cigarettes each day:_____ Number of years smoked?_____
Alcohol use: Drinks each week:_____
Recreational drug use: Yes No
Type: Marijuana Methamphetamine Ecstasy Heroine Cocaine IV Prescription Drug

**Sexually Active:** Yes No Partner: Male Female

**Contraception or Birth Control:** Abstinence Tubal Ligation Condom Diaphragm
Foam Nexplanon Depoprovera IUD Type:_____ Menopause Patch
Pill Ring Spermacide Sponge Vasectomy Withdrawal

### Gynecologic History:

Age Periods Began:_____
Length of Period (days): _____
Number of days between periods:_____
Do you have menstrual cramps? Yes/No
When was your last pap test?_____ Where?_____
Was it normal? Yes/No
Have you had an abnormal Pap test? Yes/No
Have you ever had a bone density test? If so, when and where?_____
Have you ever had a colonoscopy? Yes/No What year? _____
When was your last mammogram? _____ Where?_____
Do you do regular breast self examinations? Yes/No
Do you have any gynecologic problems? _____
_____
_____

### Family History:

Please list any medical problems that your family has had
Mother: _____
Father: _____
Sister: _____
Sister: _____
Brother: _____
Brother: _____
Other Relative-include grandparents, aunts, uncles and list maternal or paternal.
Other: _____
Other: _____
Other: _____

Epic abstraction: 9-20-16