VIVA! GYN
2450 NE Mary Rose Place, Suite 220, Bend, OR 97701
Phone (541) 323-3747 FAX (541) 323-3760

HEALTH HISTORY FORM

Name:	Age:	Birthday:
Home Phone:	Work Phone:	
Primary Physician:	Physician that sent you:	

Reason for visit today: ____
____
____

Medication:		Allergies:	

Gynecologic History

Age when menses started: _____ First day of last menstrual period:_____ How many days does it last:_____
Period occurs every <21 days:_____ 21-30 days: _____ 30-35 days:_____ >35 days: _____
Do you have menstrual cramps/pain?:_____ How severe: Mild_____ Moderate_____ Severe _____
Do you ever bleed between periods?: _____ After intercourse: _____
What do you use for contraception: ____________________________
Have you ever had:

_____ Fibroids _____ Ovarian cysts _____ Vaginal dryness/itching
_____ Endometriosis _____ Pelvic inflammatory disease _____ Hot flashes
_____ Genital herpes _____ Genital warts _____ Yeast infection
_____ Gonorrhea _____ Syphilis _____ Bacterial vaginosis
_____ Chlamydia _____ Mood swings

Have you gone through menopause: No _____ Yes _____ What age? _____
Date of last pap smear: _______________ Normal?: Yes _____ No _____
Have you ever had an abnormal pap smear?: Yes _____ No _____ Did you have: cyro colpo leep
Date of last mammogram: _____________ Normal?: Yes _____ No _____ Self breast exam? Yes _____ No _____

Sexual History

Are you sexually active?: Yes _____ No _____ Do you ever have pain with intercourse?: Yes _____ No
Is your sex life satisfactory?: Yes _____ No _____ Sexual preference: Male _____ Female _____
Any history of physical, emotional or sexual abuse Yes _____ No _____

Social History

Smoke: No _____ Yes _____ How much?: _____________ Number of years?: _____________
Drink alcohol: No _____ Yes _____ How much per week?: _____________ Seat belt?: Yes _____ No _____
Drink beverage with caffeine: Yes _____ No _____ How much per day?: _____________
Use street drugs?: No _____ Yes _____
Do you exercise regularly?: Yes _____ No _____ Describe: ____________________

Urinary Problems: (Do you have)

_____ Urine loss with cough	_____ Pain with urination	_____ Bed wetting
_____ Urine loss with urgency	_____ Blood in urine	_____ To get up at night to urinate
_____ Urinary urgency	_____ Bladder infection	_____ To wear incontinence products
_____ Urinary frequency	_____ Difficulty urinating	_____ Uncontrollable loss of stool

Obstetrical History:

Total number of pregnancies _______ Number of living children _______ Number of miscarriages _______

Ectopic pregnancies _____ Terminations _____ Difficulty getting pregnant _____

Pregnancy complications ____

Is your family complete? ____

Infant Weight	Type of Delivery Vaginal or C-Section	Infant Weight	Type of Delivery Vaginal or C-Section

Do you have to take antibiotics before going to the dentist or having a procedure? Yes _____ No _____

Have you been vaccinated for Pneumonia? Yes _____ No _____

Medical History

_____ Diabetes	_____ Anemia	_____ Cancer
_____ High Blood Pressure	_____ Bleeding problems	_____ Multiple sclerosis
_____ Stroke	_____ Liver disease	_____ Parkinson's
_____ Arthritis	_____ Osteoporosis	_____ Alzheimer's
_____ Glaucoma	_____ Gall bladder disease	_____ Fibromyalgia
_____ Tuberculosis	_____ Hepatitis	_____ HIV/AIDS
_____ Asthma	_____ Psychiatric problems	_____ Thyroid

Surgical History

Year	Operation	Hospital

Family History

_____ Breast cancer	_____ High Blood Pressure	_____ Alzheimer's
_____ Ovarian cancer	_____ Heart disease	_____ Alcoholism
_____ Uterine cancer	_____ Stroke	_____ Seizure disorders
_____ Colon cancer	_____ Parkinson's	_____ Psychiatric disorders

Have you recently had or experienced:

_____ Constipation	_____ Chest pain	_____ Weakness/Numbness
_____ Diarrhea	_____ Heart attack	_____ Suicidal thoughts
_____ Soiling pants with BM	_____ Skin problems	_____ Swollen glands
_____ Blood in stool	_____ Abnormal hair growth	_____ Breast lumps
_____ Vomiting blood	_____ Headaches	_____ Hoarseness
_____ Appetite change	_____ Change in vision	_____ Coughing up blood
_____ Sudden weight change	_____ Change in hearing	_____ Difficulty breathing
_____ Depression	_____ Difficulty sleeping	

_______________________________ _______________________________

Physician Signature Date Patient Signature Date