**NORTHWEST OB-GYN INC.** Date_________

NAME________________________________________ DOB_________________ AGE______

REASON FOR VISIT__________________________________________________________________________________________________

**Menstrual cycles:** normal/abnormal Age at first period_________ Pain during periods Yes / No_______
Period starts every_____days and last for_____ days.
Change pads/tampons every _____ hours when heaviest
Bleeding between periods Yes/ No______

Have you ever been diagnosed with Fibroids/Endometriosis/Bladder conditions?________________________

Birth Control Method_________________

Abnormal Paps in the past and treatment_______________Last pap_______________________

**Obstetrical History:** Include all pregnancies including miscarriages, ectopics, and abortions.

| Date | Length of Pregnancy | Length of Labor | Type of Delivery | Infant Wt/Sex | Complications |
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**Medical Illnesses:** Ex. Hypertension, Diabetes, Asthma, Seizures, Thyroid conditions, High cholesterol, etc..
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

**Medications:**
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

**Surgeries/Hospitals**

| Date | Procedure/ Reason for Admission | Hospital | Complications |
|---|---|---|---|
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**Family History:** Cancers: Breast____________ Ovarian____________ Uterine_________ Other________________
Other Medical Other Medical Conditions:______________________________________________________________

**Breast Problems:**_______________________________________Last Mammogram___________________

**Allergies:**_______________________________

Do you smoke?_________________ Drink Regularly?_____________________ Use Drugs?_____________

Referred by_______________________________ Family Doctor.___________________________________