



Asheville Obstetrics & Gynecology

Personal History

Date _____

Name _____ Name I Prefer _____
Last First Middle Maiden Name

Age _____ Date of Birth _____

Home Phone () _____ Work () _____ Cell () _____

Email _____ Emergency Contact Name/Number _____

Occupation _____ Where Do You Work? _____

How Did You Hear About Us? _____ Name of Family Doctor or Internist _____

Where Were You Born? _____ Level of Education Completed _____

Name of Spouse or Partner _____ Marital Status (Circle) S M D W

Reason For Today's Visit _____

Current Medications (include birth control medications, supplements and herbs)
PLEASE LIST MEDICATION AND DOSAGE:

Medication Allergies and Reactions _____

Current Illnesses or Conditions _____

Have you ever been diagnosed with MRSA? ____ Yes ____ No

Surgical Procedures, including date, hospital and surgeon (please list all procedures) _____

Type of Birth Control You're Using (Circle) Pills IUD Depo-Provera (shot) Patch Implanon
NuvaRing Diaphragm Condoms Tubal Vasectomy Foam None Not Applicable

Menstrual History First Day of Last Period _____ Number of Days of Period Flow _____
Interval Between Periods (from one to the next) _____ days

How many days with each period do you take something for cramps? _____

Age of First Period _____ Date of Last Pap Smear _____

Previous Procedures for Abnormal Pap Smear (Circle all the apply)

Cryosurgery (freezing) LEEP Cone Biopsy Colposcopy NONE

Please Circle Any Current Symptoms or Conditions

Troubling Loss of Urine Significant Headache Bleeding After Menopause
Painful Intercourse Hot Flashes Night Sweats Significant Weight Loss

OB History Number of Pregnancies _____ Number of Live Births _____

Number of Miscarriages/Abortions _____ Number of C-Sections _____

Pregnancy Complications (pre-eclampsia, diabetes, etc) to Mother or Child _____

Children's Names and Date of Birth _____

Currently Smoking (Circle) more than 1 pack per day less than 1 pack per day None

Currently Drinking (Circle) more than 1 drink per day less than 1 drink per day None
(1 drink = 1 beer = 1 glass of wine = 1 mixed drink)

What Street Drugs Do You Currently Use (Circle) Marijuana Cocaine Meth Other None

Describe Further _____

Any History of (Circle) Chlamydia Gonorrhea Syphilis Herpes Genital Warts HIV None

Describe Further _____

Any Current or Past Use of Hormone Replacement (prescribed or supplements)? (Circle)

Yes No

If Yes, Please Describe Type, Dose and When Started and Stopped _____

Date of Last Mammogram and Facility _____

Date of Last Bone Density Test and Facility _____

Date of Last Colonoscopy and Facility _____

Are you in a Relationship Where There is Verbal or Physical Abuse? _____

Please Let Us Know if We Can Help You with This

Family History (Parents/Brothers/Sisters/Children) Circle all that apply and explain further below, be sure to include what family member has the history.

High Blood Pressure

Breast Cancer

Colon Cancer

Birth Defects

High Cholesterol

Ovarian Cancer

Osteoporosis

Diabetes

Thyroid Disease

Stroke

Heart Disease

Heart Attack

Any Other Information That Would Help Us Take Better Care of You? _____

Please let us know what we can do to make your visit more comfortable.

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