



**STARK, McBRIDE, LOVE, WALLACE, VALICE, GOYMERAC & MORGAN**  
**OBSTETRICS & GYNECOLOGY, P.C.**

Thank you for choosing Oakland-Macomb Obstetrics and Gynecology! Please complete this history form, which is considered a confidential piece of your medical record. Some of the questions may seem very personal in nature, but we have found that these best help us understand your history and current issues.

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 I prefer to be called: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Telephone \_\_\_\_\_ Secondary Telephone \_\_\_\_\_  
 Concerns you would like addressed in your visit? \_\_\_\_\_

What is your ethnic background/heritage? \_\_\_\_\_  
 Primary language? \_\_\_\_\_  
 Family Doctor/Internist (name, address, phone number): \_\_\_\_\_  
 \_\_\_\_\_

Other Doctors: \_\_\_\_\_  
 Who referred you? \_\_\_\_\_  
 Please circle: Single / Married / Partnered / Widowed  
 Spouse/Partner's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_  
 City and crossroads: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

ALLERGY	REACTION
_____	_____
_____	_____

Latex Allergy? YES / NO MEDICATION/DOSE	DATE STARTED	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any herbal supplements and vitamins:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had a hysterectomy? YES / NO If yes, when? \_\_\_\_\_  
 If yes, please circle any of the appropriate following about your hysterectomy:

- Abdominal/Vaginal/Laparoscopic
- I have my ovaries            YES/NO
- I have my cervix            YES/NO
- I had abnormal paps        YES/NO
- I had cancer                YES/NO

Other Surgeries	Reason	Date	Hospital

Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Please date any conditions you currently have or have had:

- |   |                                      |
|---|--------------------------------------|
| _____ Breast cancer/Atypia                                  | _____ Tuberculosis                   |
| _____ Breast biopsy   | _____ Pneumonia/lung disease         |
| _____ Abnormal mammogram                                    | _____ Asthma/bronchitis/COPD         |
| _____ Fibrocystic breasts                                   | _____ Arthritis/back problems        |
| _____ Cervical cancer                                       | _____ Bleeding/clotting issues       |
| _____ Abnormal paps   | _____ Diabetes                       |
| _____ HIV/AIDS  | _____ Stroke                         |
| _____ Genital warts/HPV                                     | _____ Gestational Diabetes           |
| _____ Herpes  | _____ Heart Disease/attack           |
| _____ Gonorrhea   | _____ Heart Murmur/Mitral valve      |
| _____ Chlamydia   | _____ High blood pressure            |
| _____ Trichomonas   | _____ High Cholesterol/Triglycerides |
| _____ Syphilis  | _____ Hepatitis/Liver/Gall bladder   |
| _____ Pelvic Inflammatory Disease                           | _____ Kidney disease/stones          |
| _____ Uterine Cancer  | _____ Ulcer disease/reflux           |
| _____ Uterine fibroids                                      | _____ Major Accidents                |
| _____ Ovarian Cancer  | _____ Thyroid disease                |
| _____ Endometriosis   | _____ Seizures/Epilepsy              |
| _____ Infertility   | _____ Major Accidents/broken bones   |
| _____ Leaking urine   | _____ Depression/Anxiety             |
| _____ Exposure to DES                                       | _____ Osteopenia/Osteoporosis        |
| _____ My partner has herpes, HIV, HPV, or other infections. | _____ Autoimmune disease/lupus       |
|   | _____ Eating disorder                |
|   | _____ Anemia/Blood transfusions      |
|   | _____ Bowel problems                 |
|   | _____ Migraines                      |

Please list any other illnesses, cancers or important information: \_\_\_\_\_

Have you been sexually abused, threatened or hurt by anyone? \_\_\_\_\_

**Family History**

Mother: \_\_\_ Living \_\_\_ Deceased (Cause \_\_\_\_\_) Age \_\_\_\_\_  
 Father: \_\_\_ Living \_\_\_ Deceased (Cause \_\_\_\_\_) Age \_\_\_\_\_  
 Siblings: Number Living \_\_\_ Number Deceased \_\_\_ Causes \_\_\_\_\_  
 Children: Number Living \_\_\_ Number Deceased \_\_\_ Causes \_\_\_\_\_

This next section applies to your family's history. Please mark which relative/age..

- |                                 |                                 |                     |
|---------------------------------|---------------------------------|---------------------|
| _____ Breast cancer             | _____ Ovarian cancer            | _____ Colon cancer  |
| _____ Uterine cancer            | _____ Pancreatic cancer         | _____ Other cancers |
| _____ Diabetes                  | _____ Heart disease             | _____ Osteoporosis  |
| _____ High cholesterol          | _____ Thyroid disease           | _____ Stroke        |
| _____ Genetic disorders         | _____ Birth defects             | _____ Blood clots   |
| _____ High blood pressure       | _____ Hepatitis                 | _____ HIV           |
| _____ Tuberculosis              | _____ Alzheimer's               |                     |
| _____ Mental Illness/Depression | _____ Drug or Alcohol Addiction |                     |

Please list any other concerns regarding your family history: \_\_\_\_\_

Would you be interested in genetic counseling/testing if you are high risk for cancer? YES / NO

Please check any of the following symptoms that may apply to you:

\_\_\_\_\_ Hot flushes                      \_\_\_\_\_ Night sweats                      \_\_\_\_\_ Fatigue  
\_\_\_\_\_ Poor sleep                      \_\_\_\_\_ Irritability                      \_\_\_\_\_ Mood swings  
\_\_\_\_\_ Weight gain                      \_\_\_\_\_ Weight loss                      \_\_\_\_\_ Suicidal thoughts  
\_\_\_\_\_ Depression                      \_\_\_\_\_ Anxiety                      \_\_\_\_\_ Incontinence of stool

Do you have any of the following problems with urination?

\_\_\_\_\_ Incontinence with coughing/sneezing/laughing/exercise  
\_\_\_\_\_ Incontinence with urgency/running water/can't make it to restroom in time  
\_\_\_\_\_ Frequency  
\_\_\_\_\_ Pain with urination/blood in urine

Please answer the following regarding your periods:

Age first periods \_\_\_\_\_ Days of flow \_\_\_\_\_  
Date of last period \_\_\_\_\_ Days between periods \_\_\_\_\_  
Recent changes YES / NO                      Flow is LIGHT / NORMAL / HEAVY  
Have your periods stopped? YES / NO                      From MENOPAUSE / SURGERY  
Have you had an endometrial ablation or other procedure for heavy periods?  
NO / YES                      Date: \_\_\_\_\_

Are you up to date with the following? Please add date if yes.

HPV vaccination (Gardasil, Cervarix)? YES / NO \_\_\_\_\_  
Hepatitis vaccination?                      YES / NO \_\_\_\_\_  
Flu vaccination?                      YES / NO \_\_\_\_\_  
Colonoscopy?                      YES / NO \_\_\_\_\_  
Mammogram?                      YES / NO \_\_\_\_\_  
Bone density testing?                      YES / NO \_\_\_\_\_  
Advanced directives/Living will?                      YES / NO \_\_\_\_\_  
Rubella vaccination/immune?                      YES / NO \_\_\_\_\_  
Chicken pox vaccination/immune? YES / NO \_\_\_\_\_

The following are in regards to sexual practices:

Sexually active YES/NO                      Ever had sex? YES/NO  
Sex with \_\_\_\_\_ Men                      \_\_\_\_\_ Women                      \_\_\_\_\_ Both  
Number of partners in the last year \_\_\_\_\_  
Satisfied with your sex life? YES/NO If not why? \_\_\_\_\_  
Any dryness, pain with sex? \_\_\_\_\_  
Any loss of interest? \_\_\_\_\_  
Type of birth control currently using (ie., pills, tubal ligation, vasectomy) \_\_\_\_\_

**Pregnancy History**

Number of total pregnancies: \_\_\_\_\_ Number living children: \_\_\_\_\_  
Miscarriages (number and dates): \_\_\_\_\_  
Abortions (number and dates): \_\_\_\_\_  
Premature births (less than 37 weeks) (numbers and dates): \_\_\_\_\_  
Gestational Diabetes? YES/NO  
Hypertension/Preeclampsia? YES/NO  
Depression before or after a birth? YES/NO  
Any trouble getting pregnant? YES / NO  
Please list any medications, procedures used to conceive: \_\_\_\_\_

Please complete for any deliveries:

Birth date	Vaginal/Cesarean	Birth Weight	Weeks Pregnant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Social History**

How often do you exercise? \_\_\_\_\_ How long? \_\_\_\_\_ Type \_\_\_\_\_  
Ever smoked? YES / NO Packs per day ? \_\_\_\_\_ Years? \_\_\_\_\_  
Caffeine? YES / NO How many per day? \_\_\_\_\_  
Alcohol? YES / NO How many per week? \_\_\_\_\_ Years? \_\_\_\_\_  
Recreational drugs? YES / NO Type? \_\_\_\_\_  
Have you had any issues with addiction to alcohol, drugs or prescription drugs? \_\_\_\_\_

This confidential health questionnaire was completed to the best of my knowledge.

Printed name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_