Eric C. Nielson, M.D., F.A.C.O.G.
Kathleen G. Miller, W.H.N.P., C.N.M
Lindsay Breinholt, W.H.N.P., C.N.M.
Julie Frenette, F.N.P., C.N.M.

Mt Olympus Obstetrics & Gynecology

OBSTETRICS • GYNECOLOGY • INFERTILITY
WOMEN'S HEALTH • MIDWIFERY CARE

# Health History

| Name: | Age: | Date: / / |
|---|---|---|
| Allergies to Medications or Latex: | | |
| Current Medications: | | |
| List any concerns or problems you would like to discuss today? | | |

# GYN History

| Date of Last Menstrual Period / / | Date of Prior Menstrual Period / / | Length of Periods |
|---|---|---|
| Amount of Flow | Days Between Periods | Age of Onset of Menses |
| Most Recent Pap Smear | History of abnormal pap smear? Yes No | Year |
| Most Recent Mammogram | Age of Onset of Menopause | |
| Are you sexually active? Yes No | If yes, are you having sex with men, women or both? | |
| Do you have concerns with sexual dysfunction or questions regarding sexual health? Yes No | | |
| Present Method of Birth Control | Length of Use | |
| History of sexually transmitted infections: Yes No | Type | Year |
| History of sexual assault, rape or child abuse: Yes No | Year | |
| If so, have you had counseling? | | |

# OB History

| Total Pregnancies | Total Living Children | Multiple Births (twins) |
|---|---|---|
| Ectopic Pregnancies | Miscarriages | Abortions |
| Pregnancy Complications: | | |
| | | |
| | | |

## Current Health

| | | | |
|---|---|---|---|
| Do you drink alcohol? Yes No | Drinks Per Week | Do you smoke cigarettes? Yes No | Cigarettes Per Day |
| Do you use street drugs? Yes No | Type | Do you exercise? Yes No | Hours Per Week |

Are you being hit, slapped, kicked or otherwise physically hurt by someone? Yes No

Do you currently have any problems with: (Circle)

| | | | | |
|---|---|---|---|---|
| Menstrual Problems | Pelvic Pain | Difficulty with Intercourse | Vaginal irritation or discharge | Urination |
| Perimenopause Symptoms | Constipation/Diarreha | Nausea/Vommitting | Headaches or Dizziness | Infertility |
| Eyes | Ears, Nose or throat | Chest pain | Shortness of breath | Breasts |
| Bones or joints | Skin lesions, infections or Acne | Anxiety | Depression | Other |

## Past Medical History

| | | |
|---|---|---|
| Do you have any serious illness, what? | | Date: / / |
| Have you ever been hospitalized, why? | | Date: / / |
| Have you ever had problems with substance abuse? Yes No | Type: | Year: |

Have you **ever** had problems with (circle):

| | | | | | |
|---|---|---|---|---|---|
| Heart | Lungs | Asthma | High Blood Pressure | High Cholesterol | Blood Clots |
| Kidneys/Liver | Diabetes | Thyroid Problems | Hepatitis | Cancer | Migraines/Headaches |
| Bleeding Disorders | Seizures | Anxiety | Depression | Eating Disorders | Other: |

## Surgical History

List all past surgeries including cosmetic or elective surgeries

| Date | Surgery | Reason or Complications |
|---|---|---|
| | | |
| | | |
| | | |

## Family History

List any health problems affecting your family (including: High blood pressure, heart disease, stroke, diabetes, cancer, blood clots, high cholesterol, thyroid problems etc)

| | |
|---|---|
| Mother | Father |
| Sisters | Brothers |
| M. Grandmother | M. Grandfather |
| P. Grandmother | P. Grandfather |