

Eric C. Nielson, M.D., F.A.C.O.G.
 Christopher Barton, M.D.
 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.



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 at First Period
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:		

PLEASE TURN OVER

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 health conditions? If so, please list:			
Do you have anything confidential you would like to discuss in private with your provider? Yes No			

Past Medical History

Have you had any serious illnesses, 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