Brattleboro OB/GYN & Four Seasons Midwifery
21 Belmont Avenue • Brattleboro, VT 05301
p: 802-251-9965 • f: 802-275-3662 • www.bmhmedicalgroup.org

INITIAL HISTORY

NAME: _____ DOB: _____ DATE: _____

MEDICAL HISTORY

Mark the 'C' box for CURRENT conditions and 'P' for PAST conditions

C	P	*Cardiovascular*
□	□	High blood pressure
□	□	High cholesterol
□	□	Heart attack
□	□	Blood clots
□	□	Heart murmur
□	□	Stroke
		Endocrine
□	□	Chronic fatigue
□	□	Diabetes □ Type 1 □ Type 2
□	□	Thyroid disorder
□	□	Polycystic Ovarian Syndrome
		Neurological
□	□	Epilepsy
□	□	Seizures/convulsions
□	□	Migraines
□	□	Frequent headaches

C	P	*Cancer*
□	□	Cervical cancer
□	□	Ovarian cancer
□	□	Uterine cancer
□	□	Colon cancer
□	□	Breast cancer
□	□	Lung cancer
□	□	Skin cancer
		Digestive/GI
□	□	Lactose intolerance
□	□	Stomach ulcer
□	□	Crohns Disease/colitis
□	□	Diverticulosis
□	□	Hemorrhoids
□	□	Diarrhea
□	□	Constipation
□	□	Gallbladder disease

C	P	*GYN/Urinary*
□	□	Endometriosis
□	□	Frequent UTI
□	□	Kidney stones
□	□	Kidney infection
□	□	Blood in urine
		Psychological
□	□	Depression
□	□	Alcoholism
□	□	Eating disorder
□	□	Other mental illness
		Musculoskeletal
□	□	Arthritis
□	□	Osteoporosis
		Respiratory
□	□	Asthma
□	□	Hay fever/allergies

Other, not listed:

_____

_____

Have you ever been treated for:

□ Chlamydia	date treated: _____	□ Pelvic Inflammatory Disease (PID)	date treated: _____
□ Gonorrhea	date treated: _____	□ Bacterial Vaginosis (BV)	date treated: _____
□ Trichomonas	date treated: _____	□ Recurrent Yeast infections	date treated: _____
□Syphillis	date treated: _____	□ Ectopic Pregnancy	date treated: _____

FAMILY HISTORY

Please mark if there is family history of these condition in any BLOOD relatives and how they are related to you.

□ High blood pressure	_____	□ Osteoporosis	_____
□ High cholesterol	_____	□ Endometriosis	_____
□ Heart attack	_____	□ Breast Cancer	_____
□ Diabetes Type 1 or 2	_____	□ Ovarian Cancer	_____
□ Thyroid disorder	_____	□ Uterine Cancer	_____
□ Depression	_____	□ Colon Cancer	_____
□ Other mental illness	_____	□ Tuberculosis	_____

Other, not listed:_____

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SURGICAL HISTORY

Please list all operations and hospitalizations for reasons other than childbirth

DATE	HOSPITAL	SURGERY/REASON FOR HOSPITALIZATION

OBSTETRIC HISTORY

Please list ALL pregnancies in order, including pregnancy losses, terminations and preterm births

Total number of pregnancies _____ Number of births _____

DATE	HOSPITAL	WEEKS/MONTHS	Weight	Gender	COMPLICATIONS

MEDICATIONS

Please include over the counter medications, vitamins and supplements

NAME of MEDICATION	DOSE	HOW OFTEN TAKEN	INDICATION FOR MEDICATION

MEDICATION ALLERGIES

NAME of MEDICATION	REACTION	NAME OF MEDICATION	REACTION

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SOCIAL HISTORY

□ Single □ Married □ Divorced □ Living together □ Widowed
□ Lesbian □ Bisexual □ Separated □ Engaged □ Committed Relationship

Occupation _____ Highest Level of Education Completed _____
Is English your primary language? □ Yes □ No If no, what is? _____

Do you currently smoke cigarettes? □ Yes □ No How many per day? _____ How many years? _____
Have you ever smoked in the past? □ Yes □ No When did you quit? _____
Would you like information to help you quit smoking? □ *Yes* □ *No*

Are you exposed to second-hand smoke?□Yes □No How often? _____

Do you currently drink alcohol? □ Yes □ No How many per day? _____
Have you ever used alcohol? □ Yes □ No When did you stop? _____

Do you use any recreational drugs? □ Yes □ No How often? What drugs? _____
Have you ever used drugs? □ Yes □ No When did you quit? What drugs?

GYNECOLOGIC HISTORY

Age of first period _____ Date of last menstrual period _____
Menses occur every _____ days and last for _____ days.

Birth Control Method
Check any that apply currently

□ No intercourse □ Birth control pill □ Withdrawal □ Condom □Vasectomy
□Tubal ligation □ Foam or jelly □ Depo-provera □ IUD: Mirena or Paragard
□ Diaphragm □ Birth control patch □ NuvaRing □ Natural Family Planning □None

Are you interested in changing birth control methods? □ Yes □ No

When was your last Pap test? _____ Have you ever had an abnormal Pap? □ Yes □ No
Have you had the HPV vaccine? □ Yes □ No Have you ever had HPV? □ Yes □ No

If you have a history of abnormal Pap:
Have you ever had a colposcopy? □ Yes □ No □ Unsure Date: _____ Facility: _____
Were biopsies taken? □ Yes □ No □ Unsure Date: _____ Facility: _____
Have you had any treatment? (LEEP, Cyro,)□ Yes □ No □ Unsure Date: _____ Facility: _____

Do you <u>currently</u> have any of the following problems or concerns?
□ Heavy bleeding □ Spotting between periods □ Painful periods (requiring more than Tylenol, Advil)
□ Irregular periods □ Bleeding after intercourse □ Pain with intercourse □Pelvic pressure
□ Hot flashes □ Unusual discharge/odor □ Vulvar itching/irritation □ Bulging from vagina
□ Loss of urine □ Menopausal symptoms □ Concerns about STDs/STIs □ Pelvic pain
□ History of sexual abuse. If yes, have you talked with someone about this? □ Yes □ No
□ Difficulty getting pregnant. How long? _____ months

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REVIEW OF SYSTEMS

Are you experiencing problems related to any of the following systems?

Please Check All that Apply

Constitutional: □Fatigue □Fever □Chills □Unexplained weight loss □Unexplained weight gain

Eyes: □Wear Glasses or Contacts □Blurred Vision □ Floaters □Peripheral vision changes

HENT: □Sore Throat □Sinus Pain/fullness □Hearing loss □Ringing in the Ears □ Migraine □Headache □Vertigo/dizziness □Lightheadedness

Breast: □Tenderness □Lumps □Redness □Skin Changes □Nipple pain □Nipple discharge

Cardiovascular: □Chest pain □Irregular heartbeats □Palpitations □Lower extremity swelling

Respiratory: □Wheezing □Shortness of breath □Cough □Pain on inspiration

Gastrointestinal: □Reflux/heartburn □Bloating □Diarrhea □Loss of appetite □Nausea □Constipation □Vomiting

Urinary: □Leaking Urine □Urinary Frequency □Urinary Urgency □Painful Urination □Blood in urine

Gynecologic: □Painful Intercourse □Painful periods □ bleeding between periods □Heavy periods □Frequent periods □Vaginal discharge □Hot flashes □Vaginal irritation/burning □Genital lesions/ulcers □Decreased libido □Vaginal odor

Integument: □Rash □New skin lesion □Acne □Excessive hair growth

Neurologic: □Weakness of extremities □Tingling or numbness □Memory difficulties

Musculoskeletal: □Joint Pain □Hip pain □Back Pain □Knee Pain □Muscle Weakness

Endocrine: □Excessive thirst □Excessive urination □Loss of hair □Cold Tolerance □Heat Tolerance

Psychiatric: □Marital Stress □Family Stress □Job Stress □Depression □Frequent Crying □ Access anger/Irritability □Difficulty Sleeping □Anxiety

Hematologic/Lymphatic: □Lymph node enlargement □Easy bruising □Easy bleeding

Allergic/Immunologic: □Sinus allergy □Allergic Dermatitis