Date of Birth:

| Date: | |
|-------|--|
| | |



OB/GYN and Sexual Health History Form

Gynecological/Sexual History:

| First day of your last menstrual period (LMP): | | Past methods of birth control (check all that apply): | | | |
|--|--|--|--|--|--|
| How old were you when your period started? | □ Rhythm/Natural □ Family Planning □ Condoms | | | | |
| Are your periods: \Box Light \Box Moderate \Box He | □ Withdrawal □ Pill □ Patch □ NuvaRing □ Arm | | | | |
| How long are your period cycles? | _ | Implant 🗆 Depo-Provera Injections 🗆 Hormone IUD | | | |
| Do you have significant pain with your periods? | \Box Yes \Box No | □ Copper IUD □ Essure Sterilization | | | |
| Are your periods regular in their timing? | 🗆 Yes 🗆 No | □ Tubal Ligation/removal □ Vasectomy □ Hysterectomy | | | |
| How many days of menstrual flow? | | | | | |
| Do you have bleeding between periods? | 🗆 Yes 🗆 No | Ever had an abnormal Pap or Colposcopy? □ Yes □ No | | | |
| If applicable, age of menopause/year of last period | od? | | | | |
| Taken hormone medications since menopause? | 🗆 Yes 🗆 No | Have you had any treatments to your cervix? | | | |
| | | \Box No \Box Cryosurgery \Box LEEP \Box Conization | | | |
| Are you sexually active? | 🗆 Yes 🗆 No | | | | |
| Do you have pain with sexual activity? | \Box Yes \Box No | Have you ever had a sexually transmitted disease? | | | |
| Relationship status (check all that apply): | | 🗆 No 🗆 Chlamydia 🗆 Gonorrhea 🗆 Herpes | | | |
| □ Single □ Married □ Civil Union □ Domes | □ Other: | | | | |
| □ Multiple Partners □ Partnered, not cohabitati | ing | | | | |
| □ Divorced □ Widowed □ Committed Relation | Have you had the HPV vaccine (Gardasil) series? □ Yes □ No | | | | |
| Current form of birth control: | | | | | |
| Are you happy with it? | \Box Yes \Box No | | | | |

Obstetrical History: (if applicable)

| Total number of pregnancies: |
|----------------------------------|
| Number of full-term pregnancies: |
| Number of premature pregnancies: |
| Number of multiple births: |

 Number of miscarriages:

 Number of induced abortions:

 Number of ectopic pregnancies:

 Number of children living:

| Date of Delivery | Preterm Labor? (Y/N) | Gestational Age (# of weeks) | Length of Labor (# of hours) | Birth Weight | Infant Sex | Type of Delivery (Vaginal/C- Section) | Pain medication (Y/N) If yes, what type? | Delivery Doctor and place of delivery | Complications of pregnancy or labor? |
|---------------------|----------------------------|------------------------------------|------------------------------------|-----------------|---------------|--|--|---|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |