



East Bay Women's Health, Inc.

Obstetrics Gynecology Infertility
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Medical History

Name: (last) _____ (first) _____ Age: ____ Marital Status: M D S W

Occupation: _____ Height: ____ ft ____ in Weight: _____ lbs

Reason for seeing doctor:

Referred by: _____

PERSONAL MEDICAL HISTORY

Do have a history of any of the following:

Frequent Headaches	Y	N	Stomach, bowel or gallbladder problems	Y	N
Neurologic disorders	Y	N	Bladder or kidney problems	Y	N
High Blood Pressure	Y	N	Asthma, tuberculosis, or lung disease	Y	N
Diabetes	Y	N	Heart disease or rheumatic fever	Y	N
Cancer	Y	N	Psychiatric disorders	Y	N
Breast Disease	Y	N	Arthritis or auto-immune disorders	Y	N
Thyrod Problems	Y	N	Jaundice, hepatitis, or liver disease	Y	N

Please explain any of the above:

Please list any medications you are currently taking:

Are you allergic to any medications?

Please list any surgeries you have had:

Please list any other hospitalizations, the dates, and the reasons:

Please list any blood transfusions and the dates:

FAMILY HEALTH HISTORY

Please list the current age (or age at death) and any health problems of the following members of your family:

Father: _____ Deceased? Y / N Date: _____

Mother: _____ Deceased? Y / N Date: _____

Children: _____

Siblings: _____

Please check any of the following that are found in your family:

- High Blood Pressure Diabetes Cancer Heart disease Stroke
 Kidney disease Breast disease Thyroid disease

PREGNANCY HISTORY

How many times have you been pregnant? _____

Number of living children: _____

Elective Terminations/Abortions: _____

Miscarriages: _____

Twin pregnancy or multiple gestation: _____

Ectopic or Molar Pregnancies: _____

GYNECOLOGICAL HISTORY

Age when menstrual cycles began: _____ yrs

First day of last menstrual period, or if no longer menstruating, date when periods ceased: _____

Are your cycles regular? _____ Number of days between periods: _____ Length of periods: _____

Do you have premenstrual symptoms? _____ Medications used: _____

Do you have pain with your periods? _____ Medications used: _____

Are you sexually active? _____ Current method of contraception: _____

Past methods of contraception: _____

Date of last Pap smear: _____ Last Mammogram: _____

Results: _____

Do you perform regular breast self-examinations? _____

Have you ever used hormone replacement medication or oral contraceptives? _____

If so, what type? _____

Do you now or have you ever had any of the following:

Recurrent vaginal infections	Y	N	Ovarian cyst or tumor	Y	N
Vaginal discharge, itching or odor	Y	N	Abnormal bleeding	Y	N
Pelvic infection or PID	Y	N	Fibroids or uterine tumor	Y	N
Herpes or genital warts	Y	N	DES Exposure	Y	N
Endometriosis	Y	N	Arthritis or auto-immune disorders	Y	N
Gonorrhea, chlamydia, or other sexually transmitted diseases	Y	N	Loss of urine involuntarily, or with coughing, sneezing or activity	Y	N

Are there any sexually related problems you would like to discuss?

GENERAL HEALTH

Do you consider yourself: heterosexual, bisexual or homosexual? (Please circle one)

Have you ever experienced sexual or physical abuse?

The following are considered risk factors for HIV infection.

Please check any which may apply to you since 1979:

- User of IV drugs or sexual partner who uses IV drugs []
- Sexual partner who is HIV-positive or has AIDS []
- Sexual contact with a gay or bisexual man []
- Artificial insemination by donor []
- Sexual partner from an area where AIDS is common []
- Do you want a screening test for HIV infection? []

How many cigarettes do you currently smoke each day? _____ How many years smoking? _____

Past smoking history: _____

Would you like information on quitting? _____

How many alcohol-containing drinks do you have each week? _____

Have you or any members of your family been treated for alcoholism? _____

How often do you use drugs such as marijuana, cocaine, amphetamines or other recreational drugs?

Have you ever been treated for drug addiction? _____

Are you exposed to fumes or chemicals in your work? _____

Do you have any dietary restrictions? _____

Signature _____ Date _____