JISOO HAN, MD, FACOG
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TEL (732) 603-2122, FAX (732) 603-3566
www.BestChoiceObGyn.com

Today's date: _____

PATIENT HISTORY

Name _____ Date of Birth _____ Age _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Address: _____

Reason for today's visit: _____

_____

_____

GYN HISTORY

Date of last menstrual period _____ How old were you when you had your first period? _____

Are your cycles regular/monthly? Yes ☐ No ☐ How many days does your period last? _____

How is the flow of your periods? ☐ Heavy ☐ Moderate ☐ Light Do you have cramps? Yes ☐ No ☐

Do you have any other symptoms with your period? _____

If in menopause, at what age did it occur? _____

When was your last pap smear? _____ Have you had any abnormal pap smears? Yes ☐ No ☐ when? _____

Have you received HPV vaccine? Yes ☐ No ☐ If yes, what year? _____

When was your last mammogram? _____ Results: _____

Have you had any abnormal mammograms? Yes ☐ Dense ☐ No ☐

When was your last colonoscopy? _____ Results: _____

When was your last bone density? _____ Results: _____

Are you currently sexually active? Yes ☐ No ☐ If not, have you ever been sexually active? Yes ☐ No ☐

Do you currently have a partner? Yes ☐ No ☐ Partner's gender _____

How many lifetime sexual partners have you had? _____

Have you ever been treated for any sexually transmitted infections? Yes ☐ No ☐

☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Condyloma ☐ PID ☐ HIV ☐ HPV

Current birth control:

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Depo Provera

☐ Implants ☐ IUD ☐ Patch ☐ Tubal ligation ☐ Vasectomy ☐ Ring ☐ Other

OB HISTORY

	Number		Number		Number
Pregnancies	_____	Abortions	_____	Miscarriages	_____
Premature births	_____	Live births	_____	Living children	_____

BIRTH DATE	TYPE OF DELIVERY (Vaginal or C/S)	WEEKS OF PREGNANCY	BIRTH WEIGHT	GENDER	Pregnancy complications

History of depression before or after pregnancy? Yes ☐ No ☐ _____

MEDICAL HISTORY

(Example: Anemia, Asthma, Diabetes, High Blood Pressure, etc.)

SURGICAL HISTORY

(Example: appendectomy, tubal ligation, breast surgery/biopsy, laparoscopy, etc.)

Procedure:	Year:

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MEDICATIONS

Please list all medications you are currently taking, if any:

Medication	Dose

ALLERGIES

Please list any allergies (to seasons, foods, drugs):

_____

_____

_____

FAMILY HISTORY

Please list any MEDICAL CONDITIONS of your relatives:

Mother _____

Father _____

Siblings _____

Children _____

Other _____

SOCIAL HISTORY

Occupation _____

Marital status: ☐ single ☐ married ☐separated ☐divorced ☐widowed

Tobacco yes ☐ no ☐ quit ☐ #cigarettes/day or week _____ #years _____

Alcohol yes ☐ no ☐ quit ☐ #drinks / day or week _____ type (beer, wine, etc.) _____

Drugs yes ☐ no ☐ quit ☐ type:_____