Print Name:_____

Date of Birth:_____

Date:_____

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OB/GYN and Sexual Health History Form

Gynecological/Sexual History:

First day of your last menstrual period (LMP): _____
How old were you when your period started? _____
Are your periods: ☐ Light ☐ Moderate ☐ Heavy
How long are your period cycles? _____
Do you have significant pain with your periods? ☐ Yes ☐ No
Are your periods regular in their timing? ☐ Yes ☐ No
How many days of menstrual flow? _____
Do you have bleeding between periods? ☐ Yes ☐ No

If applicable, age of menopause/year of last period? _____
Taken hormone medications since menopause? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No
Do you have pain with sexual activity? ☐ Yes ☐ No
Relationship status (*check all that apply*):
☐ Single ☐ Married ☐ Civil Union ☐ Domestic Partnership
☐ Multiple Partners ☐ Partnered, not cohabitating
☐ Divorced ☐ Widowed ☐ Committed Relationship ☐ Other

Current form of birth control: _____
Are you happy with it? ☐ Yes ☐ No

Past methods of birth control (*check all that apply*):
☐ Rhythm/Natural ☐ Family Planning ☐ Condoms
☐ Withdrawal ☐ Pill ☐ Patch ☐ NuvaRing ☐ Arm Implant ☐ Depo-Provera Injections ☐ Hormone IUD
☐ Copper IUD ☐ Essure Sterilization
☐ Tubal Ligation/removal ☐ Vasectomy ☐ Hysterectomy

Ever had an abnormal Pap or Colposcopy?
☐ Yes ☐ No

Have you had any treatments to your cervix?
☐ No ☐ Cryosurgery ☐ LEEP ☐ Conization

Have you ever had a sexually transmitted disease?
☐ No ☐ Chlamydia ☐ Gonorrhea ☐ Herpes
☐ Other: _____

Have you had the HPV vaccine (Gardasil) series?
☐ Yes ☐ 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?