



Arbor Obstetrics and Gynecology Patient Health History

Dear Patient:

If you would please take a few minutes to fill out the following information it will help us to provide you with the best health care possible. I will review all of this information with you during the visit and will be glad to answer any questions you have.

Thank you,
Samantha Anderson, M.D.

Name: _____

Date of last menstrual period: _____

Approximate date and result of last pap smear: _____

Have you ever had an abnormal pap smear, if yes, please explain: _____

Do you have any medical problems, such as diabetes, high blood pressure, asthma, allergies (especially drug allergies), migraine headaches or other?

What medications do you take? Please list names and dosages. Please include name of birth control, if applicable.

Have you ever had surgery? Please list type of surgery and date performed. Please include deliveries (Vaginal or C-Section) and/or miscarriage/ abortions.

Are you sexually active? yes, currently no, but have been in the past never

What is your sexual preference? men women both I prefer not to answer

If you are sexually active are you in a monogamous relationship? yes no

Would you like to be tested for sexually transmitted diseases at your appointment today?

yes no



Name: _____

Does anyone in your family have any of the following problems? Please list who and the age when they were diagnosed if known.

Breast Cancer _____

Gynecologic Cancer _____

Colon Cancer _____

Other Cancer _____

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Thyroid Disease _____

Have you had any of the following symptoms recently (Please circle).

Recurrent fevers / chills/ excessive fatigue / swollen glands/ skin rashes / sores on the skin / chronic itching / severe headaches / episodes of fainting / seizures/ numbness or muscle weakness / cough / shortness of breath / wheezing / chest pain / palpitations / swelling of the legs / leg pain with walking / varicose veins / hot or cold intolerance / significant weight change / abnormal hair growth / excessive thirst / abnormally frequent urination / blood in the urine / flank or “kidney” pain / abnormal bruising or bleeding tendencies / history of anemia / history of blood transfusion / severe mood swings / depression / anxiety / joint pain or swelling / difficulty moving any joints / pain with intercourse / pain with menstrual cycles / vaginal discharge or odor / sores in the genital area / leaking of urine with coughing or sneezing / hot flashes / vaginal dryness / Problems or changes in sex drive

Do you do the following? Please indicate yes or no.

Self breast exam at least once a month? _____.

Wear a seatbelt in the car at all times? _____.

Engage in an aerobic exercise 3 times per week? _____.

Take a calcium supplement every day? _____.

Take folic acid or a multivitamin with folic acid in it every day? _____.

Are you exposed to violence of any type? _____.

Are there any issues or concerns which you would like to discuss that have not been addressed in this questionnaire?
