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HERITAGE VALLEY HEALTH SYSTEM

OB/GYN Associates of Sewickley
Rebecca Welch, MD
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(412) 749-8317* Fax (412) 749-8318

Previous Ob/Gyn _____

Primary Care Physician _____

Date of Service _____

Patient's Name _____ DOB _____

Reason for Visiting the Doctor

☐ Annual / PAP ☐ Pregnancy ☐ Problem _____

Menstrual History

Date last period started _____ Number of days in last period _____

Days from start to start of period _____ Age when periods started _____

Cramps or other problems with periods _____

_____

Birth Control Method

Are you currently using any method? _____Yes _____ No

If yes, which method? _____ ☐ Tubal Ligation ☐ Vasectomy

Gynecological History

Check any surgeries you've had and note the dates performed.

___Hysterectomy – year _____ Vaginal ___ or Abdominal ____

___Tubal Ligation _____ ___Ovarian Surgery _____ ___ Bladder Repair _____

___ Gall Bladder _____ ___ Breast Surgery _____ __ Cervix – Cone Biopsy _____

____ Appendix _____ ____ Tonsillectomy _____ Cryotherapy _____

____ D&C

Other _____

(Please circle)

Fibroids of uterus | Herpes/Gonorrhea/Syphilis/Chlamydia | Tubal Infections/PID

Endometriosis | Difficulty getting pregnant | Cystic breasts/ovaries

Abnormal PAP test | Vaginal warts (condyloma)

Comments _____

Sexual History

Age of onset _____ Number of partners: Current _____ Lifetime _____

Last time seen by a gynecologist? _____

Last PAP test? Date _____ Result _____

Last Mammogram? Date _____ Result _____ Where _____

Pelvic Ultrasound? Date _____ Result _____ Where _____

Medications	**Medication Allergies / Reaction**	**Over the Counter Medications**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Obstetric History

Number of pregnancies (including miscarriages, abortions and tubal pregnancies) _____

Number of delivers _____

Year	Hospital	Length of Pregnancy	Sex & Weight of infant	Type of Delivery Normal/Forceps/C-Section	Complications

Personal History (*Check off any problems with you or a family member)*

		You	Your Family	
1.	No Known Health Problems	☐	☐	_____
2.	Congenital abnormalities or genetic disease	☐	☐	_____
3.	Headaches or Nervous Disorders	☐	☐	_____
		You	**Your Family**	
4.	Thyroid, metabolic or endocrine problem	☐	☐	_____
5.	High Blood Pressure / Heart Condition	☐	☐	_____
6.	Varicose Veins / Phlebitis	☐	☐	_____
7.	Lung Problem	☐	☐	_____
8.	Breast Problem	☐	☐	_____
9.	Gall Bladder Disease, Jaundice or Hepatitis	☐	☐	_____
10.	Intestinal Problems	☐	☐	_____
11.	Diabetes	☐	☐	_____
12.	Kidney or Bladder Problem	☐	☐	_____
13.	Anemia or Blood Disorder	☐	☐	_____
14.	Blood Transfusion	☐	☐	_____
15.	Cancer (Type)	☐	☐ Who?	_____
16.	Epilepsy/Neurological Disorder	☐	☐	_____
17.	Arthritis	☐	☐	_____

Miscellaneous History

	Yes	**No**	
Do you smoke cigarettes / vape?	☐	☐	If yes, how many per day? _____
Do you use alcohol?	☐	☐	If yes, how often? _____
Do you use any other type of social drug?	☐	☐	If yes, what kind and how often? _____
Have you received a blood transfusion?	☐	☐	
Would you consent to a transfusion if absolutely necessary?	☐	☐	
Have you been exposed to Hepatitis or AIDS?	☐	☐	
Do you examine your breasts monthly?	☐	☐	
Do you exercise weekly?	☐	☐	How often? _____
Do you have a history of latex allergy?	☐	☐	
Do you have an advanced directive?	☐	☐	If yes, please provide the office with a copy.