Comprehensive Obstetric and Gynecologic History

Patient Name: _____

Date of Birth: _____

Date of Visit: _____

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1. Menstrual History

Age at first period (menarche): _____

Date of last menstrual period (LMP): _____

Cycle length (days): _____

Duration of bleeding (days): _____

Character of flow (light/medium/heavy): _____

History of irregular periods or spotting: _____

2. Obstetric History

Total Pregnancies (Gravida): _____

Full-term Births (Para): _____

Preterm Births: _____

Miscarriages/Abortions: _____

Living Children: _____

Pregnancy Details:

- Year of delivery: _____
- Type of delivery (Vaginal/C-Section): _____
- Complications (Diabetes, Hypertension, etc.): _____

3. Gynecologic History

Last Pap Smear (Date/Result): _____

Last Mammogram (Date/Result): _____

History of Abnormal Pap Smears: _____

History of STIs: _____

History of Endometriosis or Fibroids: _____

Gynecologic Surgeries (e.g., Hysterectomy): _____

4. Contraceptive & Sexual History

Current method of contraception: _____

Sexually active: (Yes / No)

History of sexual dysfunction or pain: _____

5. Menopausal Status (If applicable)

Age at menopause: _____

Symptoms (Hot flashes, dryness, etc.): _____

Hormone Replacement Therapy (HRT) use: _____

Provider Signature: _____

Date: _____