CCOG | Women's Health Group
OBSTETRICS • GYNECOLOGY • MIDWIFERY

860-276-6800

Name______________________________**Date**______________________

Date of Birth______________________________**Race**______________________

Height______________**Weight**________________**Religion**__________________

Occupation____

FAMILY HISTORY: Do you or any relatives have:

Heart disease______________________**Diabetes**______________________

High blood pressure__________________**Cancer**________________________

Birth defects/retardation____

Other medical/psychiatric problems_____________________________________

MENSTRUAL HISTORY:

Age of first period_________________**Last menstrual period**___________________

How long do periods last?_____________**Periods are: Regular Irregular**

Flow: Light Moderate Heavy **Cramps: None Few Moderate Severe**

Are you sexually active? Yes No **With: Men Women Both**

What form of birth control do you use?__________________________________

PLEASE LIST ALL PREGNANCIES:

DELIVERIES:

	Date of Delivery	Sex	Type of delivery/Complications
1.			
2.			
3.			
4.			

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EARLY SPONTANEOUS LOSSES (MISCARRIAGE):

Date of Loss	Surgery Performed/Complications
1.	
2.	
3.	

PREGNANCY TERMINATION:

Date	Medical/Surgical	Complications
1.		
2.		
3.		

PLEASE LIST ALL SURGICAL PROCEDURES:

Year	Type of Surgery	Reason for Surgery	Complications
1.			
2.			
3.			

PLEASE LIST ANY MEDICAL PROBLEMS AND TREATING PHYSICIAN:

1.____________________
2.____________________
3.____________________

PLEASE LIST MEDICATIONS & DOSAGE (include vitamins, calcium, aspirin, routine medications):

Medications	Dosage	Reason for Medication