# OB/GYN History

| History Type | Content |
|---|---|
| **Menstrual** | • Age of Menarche:<br>• Regular or Irregular Periods:<br>• Period Cycle Length:<br>• Period Duration:<br>• Intermenstrual Spotting?<br>• Post-coital bleeding?<br>• Pain with periods?<br>  ◦ If yes, before, during or after menses?<br>• Family History of Endometriosis<br>• Current Contraceptive Method?<br>• Satisfaction with Current Contraceptive Method? |
| **Obstetric** | • Pregnancies?<br>  ◦ Type of Delivery?<br>  ◦ Any complications with pregnancy or labor and delivery?<br>• Abortions?<br>  ◦ Spontaneous or Elective?<br>• Living Children? |
| **Gynecologic** | • Have you ever had a pap smear?<br>  ◦ If so, what were the results?<br>  ◦ Did you receive any treatment?<br>  ◦ When was your last pap smear?<br>• Date of Last Mammogram:<br>• Any Abnormal Mammograms?<br>• Family History of Breast, Ovarian, Cervical or Endometrial Cancer?<br>• Prior Gynecologic or Obstetric Surgeries? |
| **Social** | • Currently Sexually Active?<br>• Number of Partners:<br>• Male, Female or Both?<br>• Type of Sexual Encounters: Oral, Anal, Vaginal<br>• Protection Used?<br>• Satisfaction with Sexual Activity:<br>• Domestic Violence Screening |
| **Other** | • Alcohol Use<br>• Prescription Drug Use<br>• Illicit drug use<br>• Tobacco use<br>• Vaping and non-nicotine use |