



**San Ramon OB/GYN**  
 11030 Bollinger Canyon Road, Suite 250  
 San Ramon, California 94582  
 Phone: (925) 736-0110 Fax: (925) 736-0120

Dr. Joanne Vogel, MD, FACOG  
 Dr. Jennifer Grabenstetter, MD

**WOMEN'S HEALTH HISTORY**

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_ Date Form Completed \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

**GYNECOLOGICAL HEALTH HISTORY**

First day of last period: \_\_\_\_\_

Are your periods regular?  Yes  No  N/A

Are they heavy?  Yes  No  N/A

Are they painful?  Yes  No  N/A

Have you ever had sex?  Yes  No

How many times have you been pregnant? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Have you had any miscarriages?  Yes  No

Date of last PAP smear: \_\_\_\_\_

Results: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever had an abnormal PAP?  Yes  No

When: \_\_\_\_\_

Sexual partners are:  Men  Women  Both

Abortions?  Yes  No

**PAST MEDICAL HISTORY**

What significant illnesses have you had? \_\_\_\_\_

What surgeries have you had (with dates)? \_\_\_\_\_

**HABITS**

Do you currently or have you in the past used:

Tobacco  Yes  No

Previously

Currently  Yes  No

Frequency: \_\_\_\_\_

Alcohol  Yes  No

Yes  No

Frequency: \_\_\_\_\_

Street Drugs (including marijuana)  Yes  No

Yes  No

Frequency: \_\_\_\_\_

**FAMILY HISTORY**

Have any relatives had the following?

Cancer  Yes  No

Who? \_\_\_\_\_

High Blood Pressure / Heart Disease  Yes  No

Who? \_\_\_\_\_

Osteoporosis  Yes  No

Who? \_\_\_\_\_

Other  Yes  No

Who? \_\_\_\_\_

What concerns do you have today (reason for visit)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 Patient Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_