Diegmann & Henderson OBGYN P.C.

Name:	Date:	Chart #:

MENSTRUAL HISTORY: **Age Started:**_____

Regular ☐ **Irregular** ☐ **| Length of Flow:** _____**(Days) | Cramps** ☐ **Clots** ☐ **Headaches** ☐

Date of last Pap Smear: _____ **Normal** ☐ **Abnormal** ☐	**History of Abnormal Pap Smears?** _____

PERSONAL MEDICAL HISTORY/MAJOR ILLNESSES:

NONE		Hepatitis		Crohn's		BL Transfusion		Sickle Cell	
Heart		Asthma		Ulcers		Epilepsy		Phlebitis	
Arthritis		Cancer		STD		High BP		Varicose Veins	
Migraines		Diabetes		Thyroid		Anemia		Other	

SURGICAL HISTORY: **Date:**	**Type of Operation:**

PREGNANCY HISTORY: (List the # of times you have had the following. *including currently*)

Pregnant		Full-term Delivery		Stillborn		Premature Delivery		Miscarriage	
Abortion		Living Children		Infant Death		C-Section		Other	

List ALL Pregnancies IN ORDER: (Include abortions, miscarriages, etc.)

Sex:	Birth Weight:	Date of Birth:	RhoGAM:	Complications Before or After Delivery: