ALL WOMEN
OB/GYN P.S.C.

Patient Acct#:_____

MEDICAL HISTORY – Please complete both pages of form

Name:_____ **Date:**_____

Date of Birth:_____ **Marital Status:** _____ (S, M, W, D, Other) **Race:** _____

Preferred Pharmacy:_____ **Address:**_____

Patient's Employer:_____ **Occupation:**_____

Partner's Name:_____ **Telephone #:**_____

Partner's Employer:_____ **Occupation:**_____

Emergency Contact:_____ **Phone #:** _____ **Relationship:**_____
(Not Living With You)

Reason for visit: ☐ Preventative/Well-Women Exam
Other: (Please explain)_____

Who referred you?_____ Name of Family Doctor:_____

Medication History (List all medications that you currently take with the dose- including Vitamins, Dietary Supplements and Herbal remedies)

NAME	DOSE	FREQUENCY	PURPOSE

If additional space is needed, please continue on separate piece of paper

Do you take hormone therapy or birth control pills? ☐ Yes ☐ No If YES, please list below

_____ _____

_____ _____

Allergies (List all adverse reactions or allergies you have to medications and what happened)

_____ Reaction_____ _____Reaction _____

_____ Reaction_____ _____Reaction _____

Are you allergic to Latex?_____ **Peanuts?:**_____ **Eggs?**_____

Surgical History (List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom tooth extraction including dates)

_____Mo/Yr _____ _____Mo/Yr_____

_____Mo/Yr _____ _____Mo/Yr_____

_____Mo/Yr _____ _____Mo/Yr_____

_____Mo/Yr _____ _____Mo/Yr_____

Have you ever had any of the following conditions or diseases?

❑ Asthma ❑ Autoimmune disorder ❑ Bleeding Disorder ❑ Blood transfusion ❑ Bone/Joint Disease ❑ Chlamydia
❑ Cancer (type?) _____ ❑ Chicken pox ❑ Chicken pox vaccination ❑ Deep Vein Thrombosis ❑ Depression
❑ Diabetes Type I ❑ Diabetes Type II ❑ Elevated cholesterol ❑ Endometriosis ❑ GERD/Reflux ❑ Gonorrhea
❑ Heart disease ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ Herpes ❑ Infertility ❑ Irritable Bowel Syndrome
❑ HIV ❑ HPV/genital warts ❑ High Blood Pressure ❑ Hyperthyroidism ❑ Hypothyroidism ❑ Liver Disease
❑ Migraines ❑ Osteopenia/Osteoporosis ❑ Pelvic inflamm. disease ❑ Seizures ❑ Sleep Apnea ❑ Syphilis ❑ Tuberculosis

OTHER:_____

Well Woman Update: Please provide dates where applicable.

Last Pap Smear _____ Any Abnormal Pap Smears? _____ Yes _____ No

Last Mammogram_____ Cervical Dysplasia? _____ Yes _____ No

Last Bone Density_____ If yes, any treatment? _____ LEEP _____ Laser

Last Colonoscopy_____ _____ Cone Biopsy _____ Cryo(freezing?)

General Health

How much alcohol do you drink? ☐None ☐Avg. less than 1/day ☐Avg. 1/day ☐ Avg. more

Do you smoke? ☐ Yes ☐ No Amount/day_____ How many years:_____ If you quit smoking, when did you stop? _____

Gynecologic History

Age of first menstrual period:_____

Date of last menstrual period: _____ ☐ Menopausal ☐ Hysterectomy

Length of cycle from 1st day to 1st day each month: days ☐ Regular ☐ Irregular

Average length of each period:_____ ☐ Heavy ☐ Moderate ☐ Light

What do you use to keep from getting pregnant? ☐Nothing ☐Vasectomy ☐ Condom ☐ Rhythm ☐ Tubal ligation

☐ IUD ☐Diaphragm ☐ Birth Control Pills ☐ Patch ☐ Abstinence

Sexual History

Are you sexually active ☐ Yes☐ No

Pregnancy History

Age when you had your first child:_____

Number of times pregnant_____ Full term births_____ Premature Births _____

Elective termination_____ Miscarriages _____ Tubal pregnancies_____

Adopted children_____ Step children _____ Twins_____

	Birthdate	Birth Weight	Sex	Type of Delivery (Vag/ C-Sect)	Complications?
Child 1					
Child 2					
Child 3					
Child 4					
Child 5					

With any of your pregnancies, did you have: ☐ Gestational Diabetes? ☐Gestational Hypertension?

☐ Preeclampsia? Any Other complication? (please explain)_____

_____

Family History ☐ Adopted

Does your mother(M), father(F), sister(S), brother(B), Grandmother(GM), and/or Grandfather(GF) have any of the following?

Increased cholesterol	☐ Yes	☐ No	who?_____
Diabetes	☐ Yes	☐ No	who?_____
Increased blood pressure	☐ Yes	☐ No	who?_____
Heart attack before age 50	☐ Yes	☐ No	who?_____
Breast cancer	☐ Yes	☐ No	who?_____
Colon cancer	☐ Yes	☐ No	who?_____