OB/GYN HISTORY

Name:_____ DOB:_____ Date:____/____/____

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU CURRENTLY OR IN THE PAST 6 MONTHS

	NO	YES
1. CONSTITUTIONAL		
Weight Loss	()	()
Weight Gain	()	()
Fatigue	()	()
Night Sweats	()	()
2. EYES		
Vision Change	()	()
Pain/Pressure	()	()
3. ENT/MOUTH		
Ear Aches	()	()
Sinus Drainage	()	()
Sore Throat	()	()
4. CARDIOVASCULAR		
Chest Pain	()	()
Swelling of Legs	()	()
Heart Palpitations	()	()
5. RESPIRATORY		
Shortness of Breath	()	()
Wheezing	()	()
Chronic Cough	()	()
6. GASTROINTESTINAL		
Diarrhea, frequent	()	()
Bloody Stool	()	()
Nausea/Vomiting	()	()
Constipation	()	()
Heartburn	()	()
7. GENITOURINARY		
Blood in Urine	()	()
Pain with Urination	()	()
Frequency with Urination	()	()
Stress Incontinence	()	()
Abnormal Periods	()	()
Painful Periods	()	()
Painful Intercourse	()	()
8. MUSCULOSKELTAL		
Muscle Weakness	()	()
Joint Pain	()	()
Back Pain	()	()
9. BREAST		
Pain	()	()
Discharge	()	()
Masses	()	()
10. NEUROLOGIC		
Headache	()	()
Dizziness	()	()
Weakness	()	()
Numbness/Tingling	()	()
11. PSYCHIATRIC		
Insomnia	()	()
Depression	()	()
Anxiety	()	()
12. HEME/LYMPH		
Bruises, frequent	()	()
Enlarged Lymph Nodes	()	()
13. ALLERGIES/IMMUNOLOGIC		
Allergies	()	()
Drugs	()	()

Please List:_____

_____

PERSONAL PAST HISTORY

PLEASE CHECK THE "YES" OR "NO" BOX FOR THE FOLLOWING ILLNESSES

	NO	YES		NO	YES		NO	YES
Asthma	()	()	Arthritis	()	()	Bowel Trouble	()	()
Cancer	()	()	Chronic Lung Disease	()	()	Depression/Anxiety	()	()
Diabetes	()	()	Glaucoma	()	()	Heart Disease/Murmur	()	()
High Blood Pressure	()	()	Hepatitis	()	()	Kidney Disease	()	()
Stroke	()	()	Seizures	()	()	Venereal Disease	()	()
Thyroid Disease	()	()	Other:					

PLEASE LIST ALL CURRENT MEDICATIONS; NAMES AND DOSAGES

_____

_____

PLEASE LIST ALL MAJOR OPERATIONS			
Type	Date	Type	Date

FAMILY HISTORY			
ILLNESS	RELATIVE	ILLNESS	RELATIVE
Diabetes		Breast Cancer	
Alcoholism		Colon Cancer	
Stroke		Ovarian Cancer	
Heart Disease		Uterine Cancer	
High Blood Pressure		Skin Cancer	
		Other Cancer	

OB/GYN History

Age at First Menses_____Age at First Birth_____

Last Menstral period_____ Menopause Age_____Hysterectomy NO YES

Total # of pregnancies_____ Total # of deliveries_____Miscarriages_____

Ectopic Pregnancy_____Elective Abortion_____D&C_____

#Living children_____# Cesaren Sections_____Vaginal Delivery_____

Past Diagnostic History

Last Mammogram_____Last Bone Density_____Last Colonoscopy_____

Last Pap Smear_____Abnormal Pap History NO YES

Preferred Pharmacy Information Mail Order YES NO

Pharmacy_____

SOCIAL HISTORY

Smoking YES NO Packs per day_____ Years_____

Alcohol YES NO Drinks per day_____

Caffeine YES NO Type_____

Regular Excersise YES NO Type_____

IMMUNIZATIONS

Tetnus Date_____

Pheumovax Date_____

Flu Date_____

Patient Signature_____