

Brunswick-Hills OB/GYN
PATIENT HISTORY

Patient ID# _____

Date of Visit: _____

Name _____ Age _____ Date of Birth _____

REASON FOR VISIT: ANNUAL EXAM _____ OTHER: _____

Family Doctor _____ Other treating physicians _____

PERSONAL HISTORY

DRUG / FOOD / OTHER ALLERGIES: _____

ALL MEDICATIONS (dose & frequency) _____

SOCIAL HISTORY: Marital Status: Single Married Widow Divorced Occupation: _____

Are you sexually active? Yes ___ No ___

Do you have pain with intercourse? Yes ___ No ___

Have you ever been sexually abused or assaulted? Yes ___ No ___

Do you perform monthly self breast examinations? Yes ___ No ___

Do you exercise? Yes ___ No ___ Number of times per week _____ Type of exercise _____

Diet: Healthy ___ Unhealthy ___ Diet Program _____

Are you experiencing any stress issues: Yes ___ No ___ Type of Stress _____

Do you wear seat belts? Yes ___ No ___

Have you had any major life changes? Yes ___ No ___ Explain: _____

Living Will? Yes ___ No ___ Power of Attorney for healthcare? Yes ___ No ___

HABITS:	SMOKER	NONE ___	PAST ___	PRESENT ___	AMOUNT ___
	ALCOHOL	NONE ___	MINIMAL ___	MODERATE ___	HEAVY ___
	CAFFEINE	NONE ___	MINIMAL ___	MODERATE ___	HEAVY ___
	STREET DRUGS	NONE ___	PAST ___	PRESENT ___	AMOUNT/TYPE ___

FAMILY HISTORY:

Mother/Age _____ Health _____

Father/Age _____ Health _____

Siblings: How many? ___ Ages(s) _____ Health _____

FAMILY HISTORY OF:

Breast Cancer Yes ___ No ___

Ovarian Cancer Yes ___ No ___

Colon Cancer Yes ___ No ___

Other _____

MEDICAL HISTORY:

___ Abnormal pap smear
___ Anesthesia reaction
___ Bleeding disorder
___ Cancer
___ Cysts
___ Endometriosis
___ Hepatitis A B C
___ Intestinal problems
___ Lupus/Autoimmune disorders
___ Seizure disorder
___ Transfusions
___ Urinary problems

___ Alcohol abuse
___ Anxiety/emotional disorder
___ Blood clots
___ Cholesterol
___ Depression
___ Fibroids
___ Herpes
___ Kidney stones
___ Recurrent vaginitis
___ Sexually transmitted diseases
___ Tuberculosis

___ Anemia
___ Asthma
___ Breast problems
___ Chronic lung condition
___ Diabetes
___ Heart disease
___ High Blood Pressure
___ Liver Disease
___ Rheumatic Fever
___ Thyroid Disease
___ Ulcers

OTHER: _____

GYN HISTORY:

Blood Type _____

Last Menstrual Period _____ Duration _____ Frequency _____

Flow: Regular _____ Irregular _____ Moderate _____ Light _____

Contraceptives: present – pills/patch/injection diaphragm condoms tubal vasectomy other _____

Infertility – How long have you been attempting pregnancy? _____

DATE and RESULTS of last: Pap Smear _____

Mammography _____

Dexascan _____

Colonoscopy _____

Blood work _____

PREGNANCY HISTORY:

Total Pregnancies ____ Full Term ____ Premature ____ Miscarriages ____ Terminations ____ Ectopic ____

No History of Pregnancy ____ Family is complete with no plans for future pregnancy? Yes ____ No ____

Type of Delivery	Date of Delivery	Age of Child	Sex	Complications

SURGICAL HISTORY ____ NONE

Procedure	Year	Complications

DO NOT WRITE BELOW HERE:

WT: _____

HT: _____

BP: _____

LMP _____

MEDS _____

Patient requests an assistant in room

Patient initials: YES ____ NO ____

Assistant initials _____