

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

ALLERGIES _____

All MEDICATIONS (dose & frequency) _____

SOCIAL HISTORY: Marital status: S M W D Sep 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 _____

Safety issue – do you wear seatbelts? Yes ___ No ___

Have you had any major life changes? _____

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? ___ Age(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

___ Breast problems

___ Cholesterol

___ Depression

___ Fibroids

___ Herpes

___ Kidney stones

___ Recurrent vaginitis

___ Sexually transmitted disease

___ Tuberculosis

___ Anemia

___ Asthma

___ Blood clots

___ Chronic lung condition

___ Diabetes

___ Heart disease

___ High blood pressure

___ Liver disease

___ Rheumatic fever

___ Thyroid disease

___ Ulcers

OTHER _____

TURN PAGE OVER P P

GYN HISTORY:

Blood type_____

Last Menstrual Period_____ Age of onset_____ Duration_____ Frequency_____

Flow: Regular ___ Irregular ___ Heavy ___ Moderate ___ Light ___

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

Contraceptives: past - 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_____

Bloodwork_____

PREGNANCY HISTORY _____None

Total pregnancies_____ Full-term_____ Premature_____ Miscarriages_____ Terminations_____ Ectopic_____

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 _____