Name: _____ DOB: _____

SouthCoast HEALTH OBGYN

This is a confidential record of your medical history and will be kept secure in this office. Information contained here will not be released to any person except when you have authorized us to do so.

CURRENT PHARMACY - _____

MEDICAL HISTORY - Please indicate if you have any of the following medical conditions, even in the past. If you answer "yes", please tell us who your doctor was and where you were treated.

Epilepsy/Seizure disorder	YES	NO	Join pain/injury	YES	NO
Migraine headache	YES	NO	Breast biopsy/lumpectomy	YES	NO
Cluster headache	YES	NO	Breast cancer	YES	NO
Seasonal allergies/Sinus infections	YES	NO	Rheumatoid Arthritis	YES	NO
Asthma	YES	NO	Lupus	YES	NO
Bronchitis	YES	NO	Autoimmune disorder (other)	YES	NO
Pneumonia	YES	NO	Clotting disorder	YES	NO
Stroke	YES	NO	Easy bruising	YES	NO
Blood clot (DVT or PE)	YES	NO	Sickle cell disease	YES	NO
Heart Attack	YES	NO	Anemia	YES	NO
High blood pressure	YES	NO	Chicken pox	YES	NO
High cholesterol	YES	NO	Blood transfusion	YES	NO
Heartburn/GERD	YES	NO	Diabetes	YES	NO
Gallbladder disease	YES	NO	Thyroid disorder	YES	NO
Liver disease	YES	NO	Other endocrine disorder	YES	NO
Hepatitis	YES	NO	Rheumatic fever	YES	NO
Crohn's or Ulcerative Colitis	YES	NO	Tuberculosis	YES	NO
Constipation	YES	NO	Other infectious disease	YES	NO
Diverticulitis	YES	NO	Depression	YES	NO
Kidney disease	YES	NO	Bipolar disorder	YES	NO
Kidney stones	YES	NO	Anxiety	YES	NO
Frequent UTIs (>3 per year)	YES	NO	ADHD/ADD	YES	NO
Arthritis	YES	NO	Substance abuse/Alcoholism	YES	NO
Chronic back pain	YES	NO	Eating Disorder	YES	NO
Irritable bowel syndrome	YES	NO			

Please explain "yes" answers in detail along with treating physician, or add conditions not listed:

_____

_____

_____

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ALLERGIES/SENSITIVITIES - Please list your allergies to medications, food or other substances, including reaction:

Substance/Medication	**Reaction**	**Date**

SURGICAL HISTORY - Please list any surgeries you may have had along with the date and the name of the doctor who performed the surgery. (For example: appendectomy, cesarean delivery, knee surgery, etc.)

Date/Year	**Surgery**	**Reason performed/Diagnoses**	**Surgeon**

FAMILY HISTORY - Does anyone in your family have the following medical conditions? Please circle yes or no and indicate who has the illness and their age at diagnosis if known.

			Mother	**Father**	**Bro/Sis**	**Other**
Ovarian Cancer	YES	NO	_____	_____	_____	_____
Uterine Cancer	YES	NO	_____	_____	_____	_____
Breast Cancer	YES	NO	_____	_____	_____	_____
Colon Cancer	YES	NO	_____	_____	_____	_____
Other Cancer(s)	YES	NO	_____	_____	_____	_____
Stroke	YES	NO	_____	_____	_____	_____
Heart Attack	YES	NO	_____	_____	_____	_____
Blood Clot (DVT or PE)	YES	NO	_____	_____	_____	_____
High Blood Pressure	YES	NO	_____	_____	_____	_____
Diabetes	YES	NO	_____	_____	_____	_____
Inflam. Bowel Disease	YES	NO	_____	_____	_____	_____
Epilepsy/Seizures	YES	NO	_____	_____	_____	_____
Depression	YES	NO	_____	_____	_____	_____

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MEDICATIONS - Please provide a complete list of all your medications, vitamins, and dietary supplements including dose:

Date started	**Med/Vitamin/Supplement**	**Dose**	**Prescribed by:**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

SOCIAL -

Primary Language Spoken: _____

Marital Status: Single Married Divorced Widowed Other_____

Who do you live with? _____

Are you currently employed? YES* NO *If yes, where/what?_____

Significant others name: _____

Tobacco Use Never Rarely Occasionally Daily _____Cigarettes Daily
Alcohol Never Rarely Occasionally Daily _____drinks/week
Drug Use Never Rarely Occasionally Daily _____uses/week

Are you currently sexually active? YES NO
Have you ever/currently experiencing: Sexual Abuse Physical Abuse Emotional/verbal abuse
*If you have experienced abuse and are comfortable explaining in more detail, please do so below:

_____

_____

How many times a week do you exercise? _____

OBSTETRIC HISTORY -

Total Pregnancies: _____ Full term pregnancies: _____ Premature: _____
Abortions: _____ Miscarriage: _____ Ectopic: _____ Multiple Births: _____
How many living children do you have: _____

PREVIOUS PREGNANCIES -

Date	**Weeks gestation**	**Type of Delivery**	**Health of Child**	**Complications**

1. _____

2. _____

3. _____

4. _____

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SouthCoast HEALTH OBGYN

HEALTH MAINTENANCE -

What was the first day of your last menstrual period (if unsure, best guess)? _____
Menstruation Amount: _____ Duration of period/bleeding: _____ days.
Time in between cycles: _____ days. Are you currently using a method of birth control: YES* NO
*If yes, what method(s)? _____

Are you having any of the following symptoms that might be consistent with menopause? Please circle:
Vaginal dryness Hot flashes Night sweats Insomnia
Irregular periods Periods have stopped for > 6 months
Are these symptoms affecting your quality of life? _____
If you are already in menopause, how old were you when your periods stopped? _____

Do you have problems with any of the following during your period (circle all that apply):
Heavy bleeding Passing clots Painful periods
Irregular Periods Skipping periods Unpredictable bleeding/spotting
Mood swings Irritability Unable to perform normal tasks
Other: _____

Leakage of urine YES NO
Sexually transmitted disease YES* NO
*If yes, were you ever hospitalized or followed up? _____
Infertility or difficulty getting pregnant YES* NO
*If yes, please explain: _____

_____
Are you planning to become pregnant in the next three months? YES NO

DIAGNOSTIC STUDIES/SCREENING - Please indicate if you have had any of the following health screening. If yes, please tell us the date, why the test was done, and the results:

			Date	**Reason for test**	**Results**	**Physician**
DEXA (bone density) scan	YES	NO				
Cholesterol (Lipid Panel)	YES	NO				
Colonoscopy	YES	NO				
Mammogram	YES	NO				
Pap smear	YES	NO				
Other: _____						

VACCINATION HISTORY - Please circle which vaccines you have received and date, if known:

Hepatitis A	Cervarix	Measles/Mumps/Rubella
Hepatitis B	Tetanus	Chicken pox
Pneumovax	Pertussis	Meningitis
Zostavax(shingles)	Seasonal Flu	Other: _____
Gardasil	H1N1 Flu	