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 - _____

REASON FOR VISIT: _____

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	Joint 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	Herpes	YES	NO
Cancer	YES	NO	Sexually Transmitted Diseases	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**

ANESTHESIA – Do you or any family member have a history of problems with anesthesia? ☐ **Yes** ☐ **No**
***If yes, please describe:** _____

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**

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.				

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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: _____

Please answer the following with your usage from the past 2 months in mind

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? _____
Do you have any indoor OR outdoor cats? _____

HEALTH MAINTENANCE -

How old were you when you first started your period? _____
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)? _____

Have you had problems with any of the following during your period in the past (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: _____

_____

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**
Cholesterol (Lipid Panel)	YES	NO				
Colonoscopy	YES	NO				
Mammogram	YES	NO				
Pap smear	YES	NO				
Other: _____						

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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	

OBJECTIONS – Do you have any personal or religious objections to any form of medical treatment (i.e. refusal of blood transfusion). **YES** **NO**
*If yes, please describe: _____

_____

OBSTETRIC HISTORY -
Total Pregnancies: _____ Full term pregnancies: _____ Premature: _____
Abortions: _____ Miscarriage: _____ Ectopic: _____ Multiple Births: _____
How many living children do you have: _____
Will you be 35 years or older at the time this baby is born? ___Yes ___No

PREVIOUS PREGNANCIES -

Date	Weeks gestation	Type of Delivery	Health of Child	Complications
1.				
2.				
3.				
4.				

FAMILY HISTORY - Does anyone in your family have the following medical conditions?

			Mother	Father	Brother	Sister	Other Relatives
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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FAMILY GENETICS HISTORY (CONTINUED) – This pertains to both patient and the father of the baby and his family.

Have you had a child born with a birth defect? YES NO

* If yes please describe: _____

Did either you or the baby's father have a birth defect? YES NO

* If yes please describe:_____

Please describe **any** abnormalities that have occurred in the children of your family or the baby's father's family (birth defects, mental handicaps, inherited disease such as hemophilia, muscular dystrophy, or cystic fibrosis):

_____

_____

_____

Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)? YES NO

*If yes, have either of you had genetic counseling? YES NO

*If yes, have either of you had chromosomal testing? YES NO

Where and what were the results? _____

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

1. **Eastern Europe Jewish Ancestry** ___Mother ___Father ___Both

   If yes, have you had Tay-Sachs screening test? ___**Yes** ___**No**
   If yes, have you had a Canavan Screening test? ___**Yes** ___**No**
   Date:_____ Result: _____

2. **African American** ___Mother ___Father ___Both
   If yes, have you had sickle cell screening? ___**Yes** ___**No**
   Date:_____ Result: _____

3. **European Ancestry** ___Mother ___Father ___Both
   If yes, have you had cystic fibrosis screening? ___**Yes** ___**No**

4. **Mediterranean Ancestry** ___Mother ___Father ___Both
   If yes, have you had screening for inherited forms of anemia such as thalassemia? ___**Yes** ___**No**