

Cool Springs OB/GYN

Medical History

Name: _____ Age: _____ Date: _____

* If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

Primary Care Physician: _____ Referred by: _____

Reason for visit: _____

Yes No Are you allergic to any medications?

If yes, please list: _____

Please mark any condition that you or your family has had in the past and describe whom has had it:

Self	Family		Self	Family		Self	Family	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	von Willebrand's Disease or other Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clotting Disorder (eg, Phlebitis)	<input type="checkbox"/>		Abnormal Pap			

Describe if needed: _____

Please indicate any surgery that you have had: _____

Please describe any health problems or symptoms that you are having at this time: _____

Do you have any other concerns related to your past health history? _____

Yes No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

Yes No Do you have any religious objections to any form of medical treatment (eg, refusal of a blood transfusion)? If yes, please describe: _____

Yes No Do you smoke cigarettes? If yes, how many packs per day? _____

Yes No Do you drink alcoholic beverages?
If yes, how often? _____

What types of drinks? _____

Yes No Do you use recreational drugs?
If so, which ones: _____

Please list any medications you currently take including prescriptions, over-the-counter drugs, multivitamins, other supplements and any herbal medicines. _____

Yes No Do you have any reason to believe you may have been exposed to AIDS (eg, history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a homosexual or bisexual partner, exposure to an intravenous drug user)?

When was your last Pap test? _____

Yes No Have you ever had an abnormal Pap test?

If yes, when and how were you treated? _____

What was the diagnosis? _____

Have you ever had Gonorrhea Chlamydia Pelvic Inflammatory disease Herpes Syphilis

If yes, when and how were you treated? _____

Circle current birth control method: Pill, IUD, Vasectomy, Condoms, Depo-Provera, Tubal, Nuvaring, Patch
Other: _____

At what age did you first use birth control pills? _____ Total years of use? _____ Current brand? _____

Any side effects: _____

Yes No Have you ever used an IUD (interuterine device) for contraception?

If yes, indicate when? _____

Yes No Did you have any problems with the IUD? _____

Yes No Have you ever been treated for infertility?

If yes, please describe when and treatment received: _____

Do you have any urinary problems? Incontinence Too frequent Painful

Other: _____

What was your age at the time of your first pregnancy? _____ Total number of pregnancies? _____

Number of: Vaginal deliveries _____ C/S _____ Miscarriages _____ Abortions _____

What was your age at the time of your first period? _____ First day of most recent period? _____

What is your normal Cycle length (from day 1 of your period to day 1 of your next period): _____

Do you have: Excessive bleeding Painful periods Irregularity Clots Infrequent periods

Premenstrual problems Past treatment for this/these problems: _____

Hormone Replacement Therapy (including over-the-counter) Yes No Current brand: _____

Last bone density screening? _____ Result: _____

Do you perform a monthly self breast exam? Yes No Last Mammogram: _____

Any abnormal mammograms? Yes No Breast biopsies or surgeries? _____

Occupation: _____ Employer: _____

Marital Status: Married Engaged Single Divorced Widowed

Name of partner: _____ Contact Number: _____ Employer: _____