North Florida Obstetrical & Gynecological Associates, P.A

St. Vincent 5
2 Shircliff Way, Suite 920
Jacksonville , FL 32204
Phone: (904) 387-1401 Fax: (904) 387-3820

(Please fill out all information to the best of your ability) **Date:_____**

Patient's Name:_____ DOB: _____/_____/_____ Age:_____ Race:_____

Referred by: _____ Primary Care Physician: _____

Reason for Appt:_____ Pharmacy:_____
(Local and Mail Order)

Allergy/Reaction:_____
(Please list anything you are allergic to and the reaction it causes.)

Medication & Dosage:_____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

Y N Have you ever had a blood transfusion? **Y N** Are you willing to have a blood transfusion to save your life?

Y N Ever had an abnormal Pap Smear? If yes, treatment_____ Year:_____

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea
Y N Kidney/Bladder Problem	**Y N** Fibroids	**Y N** Blood Disorders	**Y N** Hepatitis
Y N High Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Low Blood Pressure	**Y N** Depression	**Y N** Hemorrhoids	**Y N** Genital Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Stomach Trouble	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome	
Y N Ulcer	**Y N** Anxiety	**Y N** Chlamydia	**Cancer:_____**

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History: Please list all pregnancies (including ectopic/miscarriage/abortion).

Date	Delivery Type (vaginal/cesarean)	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease
Y N High Blood Pressure
Y N High Cholesterol
Y N Blood Disorder
Y N Diabetes
Y N Thyroid Disease

Other Significant Family History:_____

Social History

Use of alcohol: **Never/Daily/Moderate**

Use of tobacco: Have you ever smoked? Y **N** choose one of the following:
Current Smoker, _____packs per day **OR**
Former Smoker, quit date_____.

Use of drugs: **Y N**

Hx of domestic violence: **Y N**

Sexually active: **Y N** Birth control method:_____

Last Pap:_____ date **Last Mammogram:_____** date **Last Bone Density:_____** date **Last Colonoscopy:_____** date