Highland OB/GYN
2301 Robeson Street Suite 201 * Fayetteville, NC 28305
(910) 485-1191 / (910) 485-6006 fax

Patient Medical History Form

Last Name:_____ **First Name**: _____ **Date of birth:** _____

Primary Care Physician: _____ Phone Number: (____) _____

Reason for referral / appointment: _____

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

Age at first period: _____
If your menstrual periods are regular; periods start every: _____ days
If your menstrual periods are irregular; periods start every:____ to ____ days (e.g.,12 to 60)
Duration of bleeding: _____ days
Does bleeding or spotting occur between periods? Yes □ No □
Does bleeding or spotting occur after intercourse? Yes □ No □
First day of last menstrual period _____ Menopause Yes □ No □
Month / day / year
Do you have pain associated with periods? Yes □ No □ Occasionally □
If yes, is the pain before? Yes □ No □ During? Yes □ No □

PREGNANCY HISTORY (Please list All pregnancies) Or Never been pregnant □

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother / Infant	Infant Sex	Infant Weight	Present Health of child

PREGNANCY RISK FACTORS Fill out this Section only if you are pregnant or planning to become pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

Down Syndrome (Mongolism)? If yes, who? _____
Other Chromosomal abnormality? If yes, specify and who? _____
Neural tube defect (spina bifida, anencephaly)? If yes, specify and who? _____
Hemophilia or other coagulation abnormality? If yes, specify and who? _____
Muscular Dystrophy? If yes, who? _____
Cystic Fibrosis? If yes, who? _____

BIRTH CONTROL HISTORY

What birth control method(s) do you currently use? _____

What birth control method(s) have you used in the past? _____

SEXUAL HISTORY

Have you ever had a sexual partner? Yes □ No □ Age you became sexually active? _____

Do you have a current sexual partner? Yes □ No □ Is your partner: Male □ Female □
Are there any concerns about your sexual activity which you may want to discuss with your Provider?
Yes □ No □ Explain: _____

PAST OBSTETRICAL / GYNECOLOGICAL SURGERIES Please check all that apply Or None □

	YEAR		YEAR
□ D&C	_____	□ ovarian surgery	_____
□ hysteroscopy	_____	□ L cyst(s) removed ovarian	_____
□ infertility surgery	_____	□ R cyst(s) removed ovarian	_____
□ tuboplasty	_____	□ L ovary removed	_____
□ tubal ligation	_____	□ R ovary removed	_____
□ laparoscopy	_____	□ vaginal or bladder repair for □ prolapsed or □ incontinence	_____
□ hysterectomy (vaginal)	_____		
□ hysterectomy (abdominal)	_____	□ cesarean section	_____
□ myomectomy	_____	□ other (specify) _____	_____

PAST SURGICAL HISTORY (Not OB/GYN)
Please list all surgeries and the year performed Or None □

Surgery	Year

PAP SMEAR / MAMMOGRAM HISTORY
Date of last PAP smear: _____ Date of last Annual Wellness Exam: _____
Have you ever had an abnormal pap smear? Yes □ No □
Have you ever had treatment for an abnormal pap smear? Yes □ No □
If yes, what type(s) of treatment have you had?
Check all that apply: Or None □
Cryotherapy Yes □ No □ Cone biopsy Yes □ No □
Colposcopy Yes □ No □ Loop excision (LEEP) Yes □ No □

Date of last mammogram: _____ (month) _____ (year) Location: _____
Have you had an abnormal mammogram? Yes □ No □ If yes, when _____

OTHER PAST GYNECOLOGICAL HISTORY Please check all that apply Or None □

	Year Treated		Year Treated
Venereal warts Yes □ No □	_____	Endometriosis Yes □ No □	_____
Herpes – genital Yes □ No □	_____	Chlamydia Yes □ No □	_____
Syphilis Yes □ No □	_____	Gonorrhea Yes □ No □	_____
Pelvic inflammatory disease Yes □ No □	_____	Vaginal infections Yes □ No □	_____
		Other _____	_____

PERSONAL MEDICAL HISTORY Please check all that apply Or None □

Arthritis □	High blood pressure □	Kidney Disease □
Diabetes: □	Heart disease □	Gallstones □

Liver Disease □ (including hepatitis)
Epilepsy □
Blood Transfusions □
Thyroid disease □
Asthma □
Emphysema □
Bronchitis □
HIV+ □
Eating Disorder □
Other: _____

CURRENT MEDICATIONS Please list ALL. Please use back of form if more room is needed

Medication	Dose	Frequency	Prescribed by

Pharmacy Information: _____

_____
Name Address

OVER THE COUNTER MEDICATIONS / VITAMINS / SUPPLEMENTS – Please list ALL

Name	Dose	Frequency	Taken for

ALLERGIES: Please list ALL known allergies Or None □

Allergy	Reaction / Symptoms

SOCIAL HISTORY:

Do you smoke Yes □ No □ packs per day _____ / cigarettes per day ___ How many years: _____
Drink alcohol Yes □ No □ ___ wine (glasses/day); ____ beer (bottles/day); ___ hard liquor (oz./day)
Use street drugs Yes □ No □ Type_____ Amount_____ Last date used _____
Exercise: Type: Yes □ No □ Type _____ How often _____
Your occupation: _____ Employer: _____
Marital Status: Married □ Single □ Widow □ Divorced □ Separated □
Do you feel threatened or unsafe in your current relationship? _____
Do you have a history of: Emotional abuse: Yes □ No □ Sexual abuse: Yes □ No □
Physical abuse: Yes □ No □ Verbal Abuse Yes □ No □

FAMILY HISTORY Please check all that apply Or None □

Diabetes □
High Blood Pressure □
High Cholesterol □
Heart Disease □
Breast Cancer □
Ovarian Cancer □
Endometrial Cancer □
Colon Cancer □
Bleeding Disorder □
Osteoporosis □
Thyroid disease □
Genetic disorder □
Other _____

If "yes" to any, please list affected relatives and which disease applies:

_____ _____

_____ _____

OTHER SYMPTOMS Please check all that apply and list the year Or None □

Have you recently experienced:

weight loss □	weight gain □	breast discharge □
hair growth □	change in energy □	Other _____
hair loss □	change in urinary function □	Other _____
change in exercise tolerance □	hot flushes/flashing □	

OTHER SCREENING EXAMINATIONS:

Date of last Colonoscopy: _____ Performed by_____

Date of last Bone Density Scan (DEXA): _____ Location: _____

ADDITIONAL COMMENTS / CONCERNS: Please list any additional comments, concerns or questions you would like to be addressed by your Provider.

_____

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

Staff Review:

Comments:

_____

_____

_____

Nurse Signature: _____ Date: _____

Updated May 2012