Name: _____ Date: _____

Past Medical History

Are you of Jewish Decent? Yes No What is your race? _____
Are you adopted? Yes No
Do you have any of the following allergies? Drug _____ Food _____ Environmental _____

Have you had any of the following health problems?

Blood

Anemia	Yes	No	Blood transfusion	Yes	No
Blood Clots	Yes	No	Leukemia	Yes	No
Varicosities	Yes	No	RH Disease	Yes	No

Neurological/Mental

Stroke	Yes	No	Depression	Yes	No
Epilepsy	Yes	No	Anxiety	Yes	No
Migraines	Yes	No	Multiple Sclerosis	Yes	No

Respiratory

Asthma	Yes	No	COPD	Yes	No
Tuberculosis	Yes	No	Pneumonia	Yes	No
Bronchitis	Yes	No	Other:		

Autoimmune

Arthritis	Yes	No	Lupus	Yes	No

Infection

Cytomegliovirus	Yes	No	Chicken Pox	Yes	No
Rubella	Yes	No	HIV/AIDS	Yes	No

Cardio/Vascular

Heart Disease	Yes	No	Hypertension	Yes	No
Rheumatic Fever	Yes	No	Other:	Yes	No

Gastro-Intestinal

Gallbladder Disorder	Yes	No	Crohns	Yes	No
Hepatitis	Yes	No	Peptic Ulcer	Yes	No
Collitis	Yes	No	Other:		

Urinary/Kidney

Renal Disease	Yes	No	Chronic UTI's	Yes	No	Other: _____
Leakage of urine?	Yes	No				

Endocrine

Diabetes	Yes	No	Thyroid Disorder	Yes	No

Musculoskeletal

Osteoporosis	Yes	No	Scoliosis	Yes	No
Other:					

Cancer

Cancer	Yes	No	What type?
Glaucoma	Yes	No	

COMMENTS:

Family Health Problems

Has anyone in **your family** had any of the following health problems?

Cancer	Yes	No	Diabetes	Yes	No
High Cholesterol	Yes	No	Diabetes in pregnancy	Yes	No
Osteoporosis	Yes	No	Hypertension	Yes	No
Birth Defects	Yes	No	Hypertension in pregnancy	Yes	No
Other:			Heart Disease	Yes	No

Surgical History

Have **you** had any of the following surgeries?

Oral	Yes	No	Orthopedic	Yes	No
Breast	Yes	No	Cardiac	Yes	No
Abdominal	Yes	No	Spinal	Yes	No
Gynecological	Yes	No	Other:		

Lifestyle/Health Habits History

Do you exercise regularly?	Yes	No
Have you ever smoked or used tobacco products?	Yes	No
Do you currently smoke or use tobacco products?	Yes	No
Have you ever used recreational drugs?	Yes	No
Do you currently use recreational drugs?	Yes	No
Have you ever used alcoholic beverages?	Yes	No
Do you currently use alcoholic beverages?	Yes	No
Do you experience sleep problems?	Yes	No

Psychosocial History

Do you feel unsafe at home and work?	Yes	No
Do you have no one to turn to for support?	Yes	No
Have you ever been hit, slapped, kicked, or otherwise hurt by someone	Yes	No
Have you ever been forced into any sexual activity against your will?	Yes	No
Are you afraid of your partner or anyone else?	Yes	No
Do you experience excessive stress at home or work?	Yes	No
Do you have inadequate financial income for necessities?	Yes	No

Sexual History

Are you currently sexually active? Yes No

Do you have sexual concerns to discuss with the provider today? Yes No

What is your sexual orientation? _____

What method of birth control do you use? _____

Are you HIV positive? Yes No

Have you ever had intercourse with someone you know has an STD? Yes No

Infection History

Have **you** ever been diagnosed with any of the following?

Yeast Infection	Yes	No	Gonorrhea	Yes	No
Trichonomas	Yes	No	Chlamydia	Yes	No
Group B Strep	Yes	No	Genital warts	Yes	No
Herpes	Yes	No	HPV	Yes	No
Syphilis	Yes	No	MRSA	Yes	No

Other:

COMMENTS:

Immunization History

Have you been vaccinated for the following?

DPT	Yes	No	Chicken Pox	Yes	No
Polio	Yes	No	Influenza	Yes	No
MMR	Yes	No	Pneumonia	Yes	No
Hepatitis	Yes	No	Tetanus Booster	Yes	No
HPV	Yes	No			

Medication History

Are you currently taking any of the following?

Prescription drugs	Yes	No	Hormone therapy	Yes	No
Over the counter drugs	Yes	No	Oral contraception	Yes	No
Vitamins	Yes	No	Other:	What medicines are you taking? _____	

What vitamins/supplements are you taking? _____

Menstrual History

At what age did you have your first period? _____

How many days do your periods last? _____

Do you have bleeding between period?	Yes	No
Do you have excessive cramping with your periods?	Yes	No
Do you have excessive bleeding with your periods?	Yes	No
Do you take medication for you cramps?	Yes	No

What was the first day of your last menstrual period? _____

Gynecological History

When was your last Pap Smear? _____ When was your last mammogram? _____

Have you ever had an abnormal pap smear?	Yes	No
Have you ever had an abnormal mammogram?	Yes	No
Do you have abnormal vaginal bleeding?	Yes	No
Do you have fibroids?	Yes	No
Do you have ovarian cysts?	Yes	No
Do you have endometriosis?	Yes	No
Have you ever been diagnosed with infertility?	Yes	No
Have you had any special gynecological procedures	Yes	No
Do you perform self-breast exams regularly?	Yes	No

What is the reason for your visit today? _____

Obstetrical History

Total # of pregnancies? _____ Live full term births? _____ Premature births? _____

Spontaneous abortions? _____ Induced abortions? _____ Stillbirths? _____

Please list your pregnancies in order including miscarriages and abortions

Date	Hospital	Type of delivery	Months	Infant weight	Name	Sex	Complications
1							
2							
3							
4							
5							

Fairfax OB-GYN Associates, P.C.
Authorization to Verbally Release Patient Information

Date: _____

I, _____, hereby authorize Fairfax OB-GYN Associates, P.C. and/ or their representatives to release any and all information pertaining to my health care, results, procedures, billing and/or accounting information to the following person's) or agencies.
In order for your bills to be paid it may be necessary to provide your insurance company with medical records. Please keep in mind mind that we may only give them that proof if you have marked the box appropriately.

Myself _____ No One _____
Insurance _____
Spouse _____
Parents _____
Other _____

I further authorize the physicians, nurse practitioners and their representatives to contact me in one or more of the following ways:

May call me: _____
At home _____
At work _____

May leave message to return call to physician's office:

At home _____ You may not leave a message: _____
At work _____
Answering machine _____

I understand that results will NOT be given or discussed over the telephone.
I understand that this office will NOT release any information to those persons who I have determined may receive this information without a separate consent. I also understand that this relates to all medical as well as account information. If I wish to make changes to the status of this form, I will do so in writing.

Patient's Signature: _____ Date: _____