Name	**Home Phone**	**Marital Status**	**Date**
Street Address	**Work Phone**	**Birthday**	
City, State, Zip	**Insurance Carrier/ID#/Group#/Phone#**	**Email Address**	

What brings you to the office today?
___ Annual Exam / Routine Care ___ Lab Work / STD Testing ___ OB Visit ___ Problem / Issue (Please describe briefly) ___ Procedure

Medications
What medications and supplements are you taking? (please list current medications and supplements)

Pharmacy
What pharmacy do you prefer? (please list address and phone number)

Vaccines	
What vaccines have you received? (please list vaccines)	**Date of Vaccination** (the year only is fine)

Allergies / Adverse Reactions	
Are you allergic to anything? (please list allergens)	**What kind of reaction do you have?** (please describe the reaction you experience to each)

Medical History					
	YES	NO		YES	NO
Abuse/Domestic Violence			Hepatitis		
Acid Reflux (GERD)			High Cholesterol		
Acne			Hypertension / High Blood Pressure		
Anemia or Blood Disorder			Infertility		
Anesthesia Complications			Kidney Disease		
Anxiety Disorder			Kidney or Bladder Problems		
Arthritis			Lung Disease		
Asthma			Osteoporosis		
Birth Defects or Inherited Disease			Ovarian Cancer		
Blood Transfusion			Past Pregnancy Complications		
Breast Cancer			Polyps		
Breast Problem			Pre-Eclampsia		
Depression			Psychiatric Illness		
Diabetes			Stroke		
Eating Disorder			Thrombophilias		
Eczema			Thyroid Problems		
Endometriosis			Varicosities		
Environmental Exposure					
Fibromyalgia			**OTHER** (please list other health problems)		
Genetic Disease					
GI Problems					
Headaches					
Heart Disease					
Heart Problems					

Genetic Screening and Infection History					
	YES	NO		YES	NO
Patient’s Age Will Be 35 or Older at Estimated Date of Delivery			Maternal Metabolic Disorder (Type 1 Diabetes, PKU)		
Thalassemia (Italian, Greek, Mediterranean or Asian Background; MCV <80)			Patient or Baby’s Father Had a Child with Birth Defects Not Listed		
Neural Tube Defect (Meningomylelocele, Spina Bifida, or Anencephaly)			Recurrent Pregnancy Loss or a Stillbirth		
Congenital Heart Defect			Medications (including supplements, vitamins, herbs, OTC drugs, illicit/recreational drugs, alcohol)		
Down Syndrome			If yes, list agents and strength/dosage		
Tay-sachsn (Jewish, Cajun, French-Canadian Background)			Any Other Genetic History		
Canavan Disease			Live with Someone with TB or Exposed to TB		
Sickle Cell Disease or Trait (African)			Patient or Partner Has History of Genital Herpes		
Hemophilia or Other Blood Disorders			Rash or Viral Illness Since Last Menstrual Period		
Muscular Dystrophy			History of STD, Gonorrhea, Chlamydia, HPV, or Syphilis		
Cystic Fibrosis			Prior GBS Infected Child		
Huntington’s Chorea			Other Infection History		
Mental Retardation/Autism			History of HIV		
If yes, was person tested for fragile X?			History of hepatitis		
Other Inherited Genetic or					

Past Hospitalizations and Surgery	
Have you been hospitalized and / or received surgery? (please list instances)	**Date of Hospitalization or Surgery** (the year only is fine)

Social History			
Currently Employed	YES / NO	**FOR PREGNANT WOMEN**	
Occupation		Smoking Pre-pregnancy	YES / NO
Education		Alcohol Pre-pregnancy	YES / NO
Marital Status		Illicit Drugs Pre-pregnancy	YES / NO
Live Alone or With Others		Anesthesia Consult Planned	YES / NO
Number of Children		Is a blood transfusion acceptable in an emergency?	YES / NO
Exercise Level		Advance Directive	YES / NO
Diet		Sexually Active	YES / NO
General Stress Level	LOW / MEDIUM / HIGH	Birth Plan	YES / NO
Smoking Status	SMOKER / FORMER / NON-SMOKER	Live With Cats / Exposure to Cat Litter	YES / NO
Chewing Tobacco		Changes in Family / Social Situation	YES / NO
Years of Tobacco Use		Frequent Air Travel	YES / NO
Smoking – How Often?	# OF PACKS PER WEEK / DAY	Occupational Health Risks	YES / NO
Smoked Since Age		Passive Smoke Exposure	YES / NO
Alcohol Intake	YES / NO	Smoke / CO Detectors in Home	YES / NO
Alcohol – How Often?	# OF DRINKS PER WEEK / DAY	Supplements	YES / NO
Years of Alcohol Use			
Caffeine Intake	YES / NO		
Caffeine – How Much?	# OF DRINKS PER DAY		
Illicit Drugs	YES / NO		
Years of Illicit Drug Use			
Seat Belts Used Routinely	YES / NO		
Sunscreen Used Routinely	YES / NO		
Regular Self Breast Exams	YES / NO		
Sexually Active	YES / NO		

Family History		
Has anyone in your family suffered from any of the following?	**√ FOR YES**	**Relationship**
Breast Cancer		
Colon Cancer		
Diabetes		
Drinking Problem		
Genetic Disorder		
Heart Disease		
High Blood Pressure		
Osteoporosis		
Ovarian Cancer		
Stroke		
Other:		

GYN History			
Date of Last Menstrual Period			
Frequency of Menstrual Period	EVERY DAYS	LASTING DAYS	LIGHT / NORMAL / HEAVY
Last Pap Smear	NORMAL / ABNORMAL		
Last Mammogram	NORMAL / ABNORMAL		
Current Method of Contraception			

Past Pregnancy History		
Pregnancy # 1		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		
Pregnancy # 2		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		
Pregnancy # 3		
Date	# of Fetuses	GA Weeks
Labor Length	Birth Weight	Sex
Delivery Type	Outcome	Anesthesia
Delivery Place	Pre-Term Labor	Source
Notes		

OB History			
Number of Pregnancies	TOTAL	FULL	PRETERM
	AB INDUCED	AB SPONTANEOUS	ECTOPICS
	MULTIPLE	LIVING	
Month / Year of Delivery	1)	2)	3)
Length of Labor	1)	2)	3)
Baby Gender / Birth Weight	1)	2)	3)
Type of Delivery	1)	2)	3)
Type of Anesthesia (if any)	1)	2)	3)
Place of Delivery	1)	2)	3)
Pre-term Labor (YES or NO)	1)	2)	3)

Have you had problems with any of the following within the past year?

General

__ Weight Loss or Gain
__ Fevers
__ Trouble Sleeping
__ Chronic Fatigue
__ Excessive Bleeding
__ Easy Bruising
__ Abnormal Thirst

Eyes

__ Itchy, Red Eyes
__ Vision Problems

Ears

__ Ear Pain
__ Ringing in Ears
__ Hearing Loss

Nose

__ Sinus Problems
__ Nose Bleeds

Mouth

__ Sore Throat
__ Mouth Sores
__ Dental Problems

Lungs

__ Coughing Up Blood
__ Shortness of Breath
__ Chronic Cough
__ Blood Clot in the Lungs
__ Painful Breathing
__ Wheezing

Cardiovascular

__ Chest Pain
__ Irregular Heart Beat
__ Ankle/Hand Swelling

Gastrointestinal

__ Frequent Diarrhea
__ Constipation
__ Bloody Stools
__ Nausea/Vomiting
__ Hemorrhoids

Urinary

__ Incomplete Urination
__ Loss of Urine
__ Painful Urination
__ Bloody Urine

Musculoskeletal

__ Muscle Weakness
__ Joint Pains
__ Joint Swelling
__ Clot in Leg Vein

Neurologic

__ Frequent/Severe Headaches
__ Dizziness
__ Seizures
__ Numbness
__ Trouble Walking
__ Fainting Spells

Skin

__ Acne
__ Unwanted Hair Growth
__ Unusual Lump or Growth
__ Dry Skin

Emotional

__ Excessive Worry
__ Depression
__ Frequent Crying
__ Serious thoughts of harming yourself or others

Menstrual Problems

__ Cramps/Pain
__ Heavy Bleeding
__ Too Frequent Periods
__ Bleeding Between Periods
__ Missed a Period
__ Other Period Issue

Pre Menstrual Problems

__ Bloating/Swelling
__ Mood Changes
__ Breast Changes
__ Headaches
__ Acne
__ Other PMS Issue

Menopause Issues

__ Hot Flashes
__ Night Sweats

Breast Problems

__ Breast Pain
__ Breast Lump
__ Nipple Discharge
__ Other Breast Issue

Other Gynecologic Issues

__ Vaginal Discharge
__ Itching/Irritation
__ Vulvar Pain
__ Vulvar lump/growth
__ Vulvar Sores

Sexual Problems

__ Painful Intercourse
__ Bleeding after Intercourse
__ Decreased Desire
__ Orgasm Problems
__ Dryness
__ Possible Exposure to STD
__ Other Sexual Issue

Would you like to discuss any of the following?

__ Contraception
__ Menopause Issues
__ Pregnancy Issues
__ Self Breast Exam
__ Sexuality Issues
__ STDs
__ Other

Signature

For Office Use

HEIGHT:			WEIGHT:			
T:	P:		R:		B / P:	
URINALYSIS	LEUK:	NIT:	BLOOD:	PROT:	GLUC:	COLOR:
URINE PREGNANCY TEST: NEGATIVE / POSITIVE						