Patient History

All About Women Obstetrics & Gynecology

Name (First)	(M.I.)	(Last)	Age	Date of Birth

Address	City	State	Zip	Phone (H)	Phone (W)
				( )	( )

Religion	Occupation	Employer	Phone (Other)
			( )

Height	Social Security No.	Marital Status	Family Physician	Referred By
		❍ Single ❍ Married ❍ Divorced ❍ Widowed		

Spouse/Guarantor

Name (First)	(Last)

Social Security No.

Date of Birth	Sex

Address

City	State	Zip

Phone (H)	Phone (W)
( )	( )

Insurance

Primary Insurance Carrier	ID No.	Group No.

Insurance Address	City	State	Zip

Policy Holder/Insured	Date of Birth	Policy Holder Employer	Relationship to Insured

Secondary Insurance Carrier	ID No.	Group No.

Insurance Address	City	State	Zip

Policy Holder/Insured	Date of Birth	Policy Holder Employer	Relationship to Insured

Medications/Allergies

Current Medications (Please list) ❑ Not Applicable

Drug Allergies (Please list) ❑ Not Applicable

Are you allergic to Latex? ❍ Yes ❍ No

Social History

Do you currently smoke? ❍ Yes ❍ No
If yes, how much? _____ How often? _____
If no, have you ever smoked? ❍ Yes ❍ No Last time _____

Do you:	If yes, how much?	How often?
Drink alcohol? ❍ Yes ❍ No		
Drink caffeine? ❍ Yes ❍ No		
Use non-prescription drugs? ❍ Yes ❍ No		

Family History (List any medical problems/illnesses)

Mother ❑ Not Applicable	Mother's Parents ❑ Not Applicable
Father ❑ Not Applicable	Father's Parents ❑ Not Applicable
Siblings ❑ Not Applicable	Aunts ❑ Not Applicable
Cousins ❑ Not Applicable	Uncles ❑ Not Applicable

Gynecological History

Date of Last Menstrual Period	Age Menstruation (period) began

Interval of Menses (Number of days between periods)	Duration of Menses (days)

Contraception Method: _____

Have you previously used oral contraceptives? ❍ Yes ❍ No How long?

Do you have cramps during menstruation? ❍ Yes ❍ No
If yes, rate degree of discomfort: ❑ Mild ❑ Moderate ❑ Severe

Have you had any exposure to:
❍ DES ❍ Vaginal Warts ❍ Chlamydia
❍ Gonorrhea ❍ Yeast ❍ Herpes

Have you had a Mammogram? ❍ Yes ❍ No If yes, when? _____

Have you had an Abnormal Pap? ❍ Yes ❍ No
If yes, when? _____ How was it treated? _____

▼ Continued on back ▼

Obstetrical History (List most recent first)

Date	Delivery Type	Anesthesia	Baby's Weight	Sex	Complications
	❍ C-section ❍ Vaginal				
	❍ C-section ❍ Vaginal				
	❍ C-section ❍ Vaginal				

Miscarriages/Abortions (List most recent first)

Date	Weeks Pregnant	Complications	Hospital	Physician

Surgical History (List all surgeries)

Date	Surgery	Physician	Hospital	Complications

Medical History

Do you have a history of any of the following? If yes, please explain briefly below.

❍ Heart Problems ❍ Hypertension ❍ Diabetes ❍ Asthma ❍ Thyroid Problems ❍ Heart Burn

❍ Kidney Problems ❍ Kidney Stones ❍ Bladder Infection ❍ Stress Incontinence ❍ Pain with Urination ❍ Urinary Tract Infections

❍ Colitis ❍ Constipation ❍ Rectal Bleeding ❍ Hemmorrhoids ❍ Migraines ❍ Seizures ❍ Anxiety ❍ Depression

❍ Phlebitis or Blood Clots ❍ Varicose Veins ❍ Anemia ❍ Blood Transfusions

❍ Chicken Pox ❍ Rubella/Measles ❍ Tuberculosis ❍ Hepatitis ❍ HIV ❍ Arthritis

❍ Other: (Please list)

Explanation (s) _____

_____

Please list major injuries ❑ Not Applicable

Do you have pain? ❍ Yes ❍ No

If yes, please rate the level of pain:

Least painful Most painful

1 2 3 4 5 6 7 8 9 10

Insurance Payment

I request that payment to the authorized Insurance Carrier (or) Medicare listed above benefits be made either to me or on my behalf to the name of the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature _____ Date _____

All About Women Obstetrics & Gynecology

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