Patient History Form

Obstetrics & Gynecology South, Inc.

Date: ___/___/____

Name: _____ Spouse: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Age: _____ DOB: ___/___/____ Circle One: Single Married Widowed Divorced Separated

Race: _____ Hispanic: Yes/No

Preferred E-Mail Address: _____

Preferred form of communication: ___Patient Portal, ____Phone: Cell _____Home_____

Preferred Pharmacy: _____ Telephone #: _____

Address:_____

Doctor: _____ Referred By: _____

Name of Friend or Relative (not spouse): _____ Phone: _____

Employment (Self): _____ Phone / Dept: _____

Employment (Spouse): _____ Phone/ Dept: _____

Primary Insurance Co: _____ Policy #: _____ Group#: _____

Ins. Addr. (on card): _____ Subscriber: _____/___/____
Name DOB

Secondary Insurance Co: _____ Policy #: _____ Group#: _____

Ins. Addr. (on card): _____ Guarantor: _____/___/____
Name DOB

Patient SSN: _____ Subscriber SSN: _____

I authorize the release of any medical information necessary (including drug, alcohol and HIV/Aids) to process a claim and hereby assign benefits payable to Obstetrics & Gynecology, South, Inc. for any medical and/or surgical charges incurred. Any services not covered by my insurance will become my responsibility for full payment of services rendered by Obstetrics & Gynecology, South, Inc.

_____
Signature

What is your main reason for coming to the doctor today?_____

Menstrual History

Age at which periods started: _____ Number of days separating the beginning of each cycle: _____

# of days period lasts: _____ Date of last pap smear: ___/___/___ Date of last period start: ___/___/___

Periods occur regularly? _____ Cramps or pains? _____ Are your periods: Light Medium Heavy

If menopausal, age at which periods ended: _____ Have you ever taken hormones? _____

What are you using for Birth control? _____

If using pills, patch or injections, do you understand the risks associated with their use? _____

Pregnancy History

# of pregnancies: _____ # of therapeutic abortions:_____

# of miscarriages: _____ # of children born alive: _____ # of stillbirths: _____

If you had any miscarriages, how far along were you?

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Date: ___/___/___ Duration of Pregnancy: _____

Have you ever had any blood transfusions? _____

Have you ever taken a fertility drug of any kind? _____ Which? _____

Have any of your children had birth defects of any kind? Describe fully:_____

_____

Summary of Previous Pregnancies:

Date	#Weeks	Hours Labor	Birth Weight	Sex	Delivery Type	Anesthesia	Early Labor	Comment/ Complications	Location

Date of Last: Mammogram_____
Bone Density_____
Cholesterol_____
Colonoscopy_____

The high-risk factors for cervical and vaginal cancer include any of the following: please mark any of the following that apply to you.

__ Early onset of sexual activity (under 16 years of age)
__ Multiple sexual partners (five or more in a lifetime)
__ History of any sexual transmitted disease (including HIV infection)
__ Fewer than three negative pap tests within the previous seven years
__ DES (diethylstilbestrol)
__ History of cancer

Have you ever had any of the following operations/procedures? Please check any that apply.

____ Tonsils ____ Laparoscopy ____ D & C ____ Surgery for Endometriosis
____ Appendectomy ____ Tubal Pregnancy ____ C-Section ____ Hemorrhoidectomy
____ Gallbladder (open or Laparoscopy) ____ Tubal Ligation ____ Breast Biopsy
____ Mastectomy (please specify which breast) ___left ____ right ____ both
____ Lumpectomy (please specify which breast) ___ left ___right ____ both
____ Bladder Repair ____ Leep ____ Colposcopy ____ Ovaries Removed: ___ left ___ right ___ both
____ Hysterectomy, type: ___ Vaginal ___ Abdominal ___ Laparoscopic ___ Davinci
Reason for hysterectomy_____

Please list Any surgeries not listed above _____

Have you ever had any of the following? Please check all that apply.

____ Stroke(CVA) ____ Syphilis ____ Unusual Hair Growth ___Abnormal pap smear
____ Breast Lumps ____ Hepatitis A,B,or C ____ Kidney Infection ____Gonorrhea/Chlamydia
____ TB ____ Seizures ____ Bladder Infection (frequent) ____ Asthma
____ Anemia ____ Broken Bones ____ Stomach Ulcer ____GERD
____ Diabetes and Type 1 ___ 2 ___ or gestational ____ ___Frequent Headaches/migraines
____ Herpes Genital or Oral ___Loss of urine when coughing _____Urgency of urination
____ Low Thyroid ____ High Thyroid ___ Hyperlipidemia ____High Blood Pressure
____ Depression ____ Anxiety ___Mood Disorder
____ DVT (blood clot in leg) ____ PE (blood clot in lung)
____ Any heart related problems- Please specify_____
____ Cancer: What Type_____

Please list any hospitalizations other than surgical and childbirth: _____

Which childhood immunizations have you received? Please check any that apply.

___Polio ____ DPT ____ Measles ____ Rubella ____HPV
___Tetanus ____ Hepatitis ____ Mumps ____ Smallpox

Which adulthood immunizations have you received? Please check any that apply.

___Flu ____ Pneumonia ____ Hepatitis ____ TB Skin Test ____HPV (Gardasil)

Which of the following habits do you practice?

___Smoking ____ Packs Per Day ____ Number of Years ____ Drug Use
___Alcohol ____ Drinks Per Day ____ Drinks Per Week

Please list any medications you take regularly

Medication Name	Dosage	Reason for Medication

Please list any allergies you have:	Reaction from taking this:

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Aunt	Uncle
High Blood Pressure										
Diabetes										
Breast Cancer										
Uterine Cancer										
Colon Cancer										
Ovarian Cancer										
Other Cancer type:										
Thyroid Trouble										
Kidney Trouble										
Heart Disease										
Anemia										
Birth Defects										

Review of Systems – Please check any symptom you are currently experiencing:

CONSTITUTIONAL	**RESPIRATORY**	**SKIN/INTEGUMETARY**
☐Fatigue	☐Shortness of Breath	☐Rash
☐Fever	☐Chronic Cough	☐New Skin Lesions
☐Chills	☐Spitting Up Blood	☐Changes to Existing Lesions
☐Feeling of Uneasiness	☐Wheezing	☐Acne
☐Night Sweats	☐Painful Breathing	☐Hair Growth Changes
☐Loss of Appetite		☐Unwanted Facial Hair
☐Weight Loss	**GASTROINTESTINAL**	
☐Weight Gain	☐Nausea	**NEUROLOGICAL**
	☐Vomiting	☐Numbness/Tingling
EYES	☐Diarrhea	☐Difficulty Concentrating
☐Eye Discomfort	☐Abdominal Pain	☐Seizures
☐Double Vision	☐Hemorrhoids	☐Muscular Weakness
☐Blurred Vision	☐Reflux/Indigestion	☐Memory Difficulties
☐Corrective Lens	☐Change in Bowel Habits	☐Speech Difficulties
	☐Constipation	
HEENT	☐Jaundice	**ENDOCRINE**
☐Headaches	☐Bloody Stool	☐Secretions from Breasts
☐Thyroid Lump		☐Abnormal Hair Growth
☐Neck Pain or Stiffness	**GENITOURINARY**	☐Hot Flashes
☐Earaches	☐Urgency of Urination	
☐Sinus Problems	☐Frequency of Urination	**PSYCHIATRIC**
☐Mouth Sore	☐Pain with Urination	☐Anxiety
☐Dental Problems	☐Night Time Urination	☐Depression
	☐Incomplete Emptying	☐Difficulty Sleeping
BREASTS	☐Incontinence/Loss of Urine	☐Suicidal Thoughts
☐Lumps	☐Decrease Sex Drive	☐Homicidal Thoughts
☐Tenderness	☐Painful Intercourse	☐Mood Swings
☐Swelling	☐Vaginal Discharge	
☐Nipple Discharge	☐Possible Pregnancy	**HEMATOLOGIC/LYMPHATIC**
☐Abnormal Changes	☐Significant PMS	☐Bruises: Frequent/Easily
☐Pain in Breasts	☐Genital Sores	☐Enlarged Lymph Nodes
	☐Abnormal Periods/Bleeding	☐Cuts Do not Stop Bleeding
CARDIOVASCULAR	☐Pelvic Pain	☐Lupus
☐Chest Pain		☐Rheumatoid Arthritis
☐Irregular Heart Beat	**MUSCULOSKELETAL**	
☐Sudden Loss of Strength	☐Joint Pain	
☐Varicose Veins	☐Changes	
☐Leg Swelling		