SOUTHEAST OBSTETRICS AND GYNECOLOGY, P.C.

CONFIDENTIAL PATIENT HISTORY

Name_____ Phone #_____ Date_____
Date of Birth_____ Age_____ Marital Status S M Sep W D Eng
Primary Care Provider_____ Preferred Pronouns_____Ethnicity _____
Highest level of education completed 7 8 9 10 11 12 13 14 15 16 >16 Degree_____
Occupation_____ Employer _____

MEDICATIONS please list medications currently taking (or review med list with personnel once arrived)

_____
_____
_____

Birth Control_____
ALLERGIES_____

Do you have any problems or concerns that you would like to be addressed by your physician today?

_____
_____

MEDICAL HISTORY/REVIEW OF SYSTEMS

	Y	N	now		Y	N	now		Y	N	now
Weight gain/loss				Diabetes				Varicose veins			
Marked fatigue				High blood pressure				Shortness of breath			
Ear/Nose/Throat problems				Thyroid disease				Asthma			
Bleeding disorder				Depression				Kidney problem			
Blood clots				Anxiety				Urinary tract issues			
Anemia				Numbness/tingling				Stomach/bowel issue			
H/O blood transfusion				Seizures				Liver disease			
Palpitations				Headaches				Skin problems			
Chest pain				Osteoporosis				Cancer (type)			
Other illnesses/disorders (please list)											

PREGNANCY HISTORY

Please list all pregnancies- type includes vaginal deliveries, c-sections, terminations, miscarriages and ectopic pregnancies.

Date	Type of pregnancy (as above)	Weeks	Weight	Sex	Complications

SURGICAL HISTORY

Date **Type**

_____
_____
_____
_____

HOSPITALIZATIONS

Date **Reason**

_____
_____
_____
_____

FAMILY HISTORY

Are you adopted? Y / N

Fill in the family history for relatives below Mother = M, Father = F, Brother = B, Sister = S, Grandparents (MGM, MGF, PGM, PGF), A/U

	Y	N	Who?		Y	N	Who (Age)?
Diabetes				Osteoporosis			
Heart Disease				Hip fracture			
High blood pressure				Breast cancer			
High cholesterol				Ovarian cancer			
Stroke				Uterine cancer			
Thyroid disease				Colon cancer			
Sickle cell disease				Cervical cancer			
Developmental delay/ birth defects				Other cancers			
Anxiety/Depression Psychiatric disorders				Other hereditary disorder (list)			

GYNECOLOGIC HISTORY

Age period started_____ Last menstrual period_____
Periods come every _____ days and last for _____ days
Periods are ___regular ___irregular
___light ___moderate ___heavy
Do you have severe cramps with your period? **Y / N**

Are you sexually active? Y / N / Never
My partner is Male / Female

Do you have now, or have had the following problems?	**Y**	**N**	**Now**
Bleeding between periods			
Vaginal discharge/infections			
Sexually transmitted disease ___Syphilis ___Gonorrhea ___Trichomonas ___ Chlamydia ___Herpes ___ Genital warts ____HIV			
Abnormal pap smears			
Abnormalities of the uterus (fibroids)			
Tumors/cysts on ovaries			
Infertility			
Endometriosis			
Sexual difficulty			
Pain / bleeding with intercourse			
Bothersome loss of urine			

Y	N	**WELLNESS**
		Smoke? How much per day _____ How many years?_____
		Drink alcohol? How much per day _____ How many years?_____
		Use street drugs? What?_____
		Caffeine? How much per day _____ How many years?_____
		History of physical, emotional, sexual abuse? (Please circle)
		Get enough calcium daily?
		Do monthly breast self checks?
		Always wear your seat belt?
		Exercise regularly? How many times per week? _____
		Follow a healthy, balanced diet?
		See your dentist regularly?
		Do you have a health care proxy?

HEALTH SCREENINGS

Date of last test/immunization

Pap smear _____

Mammogram _____

Cholesterol test _____

Colonoscopy (>50) _____

Stool blood test (>50) _____

Last visit with Primary Care _____

Immunization up to date **Y / N**
3 Gardasil (HPV) vaccines received (if < 27 yo) **Y / N**

Do you have any safety concerns? Y / N