# Patient Medical History

Today's Date: _____ Appt. Date_____ Provider you are seeing_____
First Name _____ MI _____ Last Name_____
Date of Birth_____/_____/_____ Name of Primary Care Physician: _____

## Medications

**Please list all medication or treatments you are currently taking. Include over-the-counter or herbal drugs.**

| | Medications | Dosage | Frequency | Reason |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |

## Allergies

**Iodine or seafood** Yes_____ No_____ **Latex** Yes _____ No_____
**Peanuts** Yes_____ No_____
**Medications** Yes_____ No _____ Specify Medications_____

## Social History

**Alcohol** Never_____ Yes _____ what, when, and how much_____
**Tobacco** Never_____ Yes _____ what, when, and how much_____
**Drug Use** Never_____ Yes _____ what, when, and how much_____
**Exercise** Never_____ Yes _____ what, when, and how much_____

## Past Medical History

**Please answer yes/no to the following questions. Specify any yes answers in further detail below.**

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Thyroid Disease | | | Kidney/Bladder Disease | | |
| Heart Disease | | | Diabetes | | |
| Hypertension | | | Gallbladder Disease | | |
| Lung Disease | | | Cancer | | |
| Anemia | | | Psychological | | |
| Blood Transfusions | | | Liver Disease | | |
| Blood clots, phlebitis | | | Gastrointestinal | | |
| Migraine Headaches | | | Rectal | | |
| Urinary | | | Neurological | | |
| Autoimmune | | | Musculoskeletal | | |

_____
_____

## Past surgical History

**Please list all major surgeries or hospitalization in the table.**

| Mo/Year | Procedure | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please be aware that it is the policy of Northwest OB-Gyn Physicians to <u>not</u> withhold blood products if it may be required to save the life of the patient.

## Family Medical History

Are there any genetic diseases that run in your family? ☐ Yes ☐No Please specify below in detail.

| Medical Problems | Mom | Dad | Sibling | Maternal Grandpa | Maternal Grandma | Paternal Grandpa | Paternal Grandma | Mat Aunt | Mat Uncle | Pat Aunt | Pat Uncle | Child |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Neurologic Disorder | | | | | | | | | | | | |
| Bleeding / Clotting Disorders | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | |
| - Breast | | | | | | | | | | | | |
| - Uterine | | | | | | | | | | | | |
| - Ovarian | | | | | | | | | | | | |
| - Cervical | | | | | | | | | | | | |
| - Colon | | | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | |
| Liver Disease | | | | | | | | | | | | |
| Endocrine | | | | | | | | | | | | |
| Psychologic Disorder | | | | | | | | | | | | |
| Autoimmune/ Rheumatologic Disorders | | | | | | | | | | | | |
| Other Genetic Disorders | | | | | | | | | | | | |
| Birth Defect | | | | | | | | | | | | |
| Pelvic relaxation/prolapse | | | | | | | | | | | | |

What ethnicity do you consider yourself to be? please check one ☐ White ☐Black/African American ☐Hispanic
☐Asian/Pacific Islander ☐Native American/Alaskan Native ☐Other

## Obstetrical History

**How many pregnancies have you had? _____ Please list them all and the outcome of each below.**

| | Date | Gestational weeks | Length of labor | Type of delivery | Sex M/F | Birth weight | Place of Birth | Preterm Y/N | Complication |
|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |

## Gynecologic History

At what age did you start having Periods? _____ What is your Period Duration _____
Date of Last Menstrual Period_____ Date of last Pap_____
Date of Prior Menstrual Period _____ Date of last Mammogram_____
Do you have Regular Periods? How often? _____ Date of last Bone Scan _____

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Painful Periods | | | Problem with intercourse | | |
| Other Symptoms during a period | | | Breast discharge/ tenderness/ lumps | | |
| Heavy Bleeding | | | Infertility | | |
| Bleeding between cycles | | | Birth Control | | |
| Abnormal Vaginal Discharge/Itch | | | Permanent Sterilization | | |
| History of STD's | | | Hormone Therapy | | |
| History of abnormal Pap Smears | | | Pelvic relaxation/prolapse | | |
| Sexually active | | | Other gynecologic issues | | |

This form completed by me the patient and is accurate to the best of my knowledge _____
Patient Signature Date