NORTHWEST OB·GYN

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

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												

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.									
5.									

Gynecologic History

At what age did you start having Periods? _____
Date of Last Menstrual Period _____
Date of Prior Menstrual Period _____
Do you have Regular Periods? How often? _____

What is your Period Duration _____
Date of last Pap _____
Date of last Mammogram _____
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