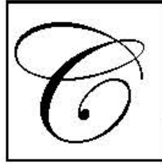

Contemporary Obstetrics and Gynecology, P.C.

NAME: ______________________________ DATE: ___/___/____ BIRTHDATE: ___/___/____
MM / DD / YYYY MM / DD / YYYY

REFERRED BY: ________________________________ AGE: ________

REASON FOR VISIT: □ ROUTINE PHYSICAL □ PROBLEM

DESCRIBE PROBLEM: ____

____

HEALTH HISTORY:

MAJOR ILLNESS	YES	NO	NOTES
Hypertension			
Diabetes			
Asthma			
High cholesterol			
Stroke			
Heart disease			
Anxiety/Depression			
Cancer			
Other(Describe)			

PREVIOUS TEST / IMMUNIZATION:

TEST	DATE/YEAR	NOTES (ex. normal/abnormal)
Pap smear		
Mammogram		
Bone density		
Colonoscopy		
OTHER		

SURGICAL/ HOSPITALIZATION HISTORY:

SURGERY/REASON	DATE	SURGERY/REASON	DATE

MEDICATIONS LIST:

DRUG NAME	DOSE	DRUG NAME	DOSE

ALLERGIES TO MEDICATIONS/SUBSTANCES: ____

FAMILY HISTORY:

MAJOR ILLNESS	YES	NO	WHAT RELATIVE? AGE OF DIAGNOSIS
Diabetes			
High Blood Pressure			
Heart Disease			
Blood clot/ DVT			
Breast cancer			
Ovarian cancer			
Uterus cancer			
Cervical cancer			
Colon cancer			
Any other cancer(describe)			
Osteoporosis			
Any other illness(describe)			

MENSTRUAL HISTORY:

Age of onset of period: _______ Date of last period: _________

How often do you get your period? ______days

How long does the period last? ______days Flow: Light / Medium / Heavy

Do you have cramps? YES/NO Do you have breakthrough bleeding? YES/NO

Do you use birth control? YES/ NO If yes what form? _____________________

If using IUD/Nexplanon please write date of insertion: _____________________

Have you gone through menopause? YES/ NO If yes at what age_________

Are you on any form of hormone replacement therapy? YES/NO _____________________

REPRODUCTIVE HISTORY:

	NUMBER		NUMBER
Total # of pregnancies		Miscarriages	
Full term births		Abortions induced	
Preterm births		Ectopic	
Living children			

DELIVERY DETAILS:

No.	DATE	NAME	SEX	VAGINAL/CESAREAN	COMPLICATIONS/COMMENTS	DELIVERY LOCATION

SOCIAL HISTORY: (Please list habits)

Exercise ☐None ☐Less than 3 times per week ☐More than 3 times per week

Smoking ☐Yes ☐No

Packs per day __________ Number of years __________

Alcohol ☐Yes ☐No

Drinks per day _________ Drinks per week __________

Drug user ☐Yes ☐No

Kind ___________________ Frequency ____________

Employed: ☐Full time ☐Part time ☐Student ☐Retired ☐Disabled

Occupation: ____

Marital status: ☐Single ☐Engaged ☐Married ☐Widowed ☐Divorced

PATIENT CERTIFICATION

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

X____ ______/______/______

(Patient's Signature) (Date)

X____ ____________________________

(Person Authorized to Sign) (Relationship to Patient)