Patient History Form

Name_________________________________ Date__________

DOB___________ mm/dd/yy

Marital Status: ____single ____married ____divorced____widowed

Husband / Partner's name: _______________________ Pharmacy: _____________________________

Pharmacy Location: ______________________

Drug Allergies: ❒ Yes ❒ No Bloodless surgery/Jehovah's witness? ❒ Yes ❒ No

Latex allergy? ❒ Yes ❒ No

OBGYN has converted over to a new computer system, we are now able to have access your prescriptions at each pharmacy you currently use. Will you allow us to have access to that information? ❒ Yes ❒ No

Reason for Visit: ____

When was your last menstrual period? __________ Are you menopausal? ❒ Yes ❒ No Age at menopause?_____

What do you use for birth control? ____________________________ (pills, patch, IUD)

If nothing, have you ever taken birth control? ❒ Yes ❒ No What type? _______________

When was your last pap smear? __________

Have you ever had an abnormal pap? ❒ Yes ❒ No How was it treated?__________________ what year?_____

Did your pap return to normal? ❒ Yes ❒ No

Have you had a Hysterectomy? ❒ Yes ❒ No --- ❒ uterus removed only? OR ❒ uterus/cervix removed?

Were your ovaries removed? ❒ Yes ❒ No

When was your last: Bone Density Scan?__________ Mammogram?_________ Colonoscopy?__________

was the result normal? ❒ Yes ❒ No

Your Medical Illness (example: High Blood Pressure / Diabetes): Who is your Primary Care Doctor?

1.____ ________________________________

2.____

3.____

4.____

5.____

6.____

7.____

8.__________________________________

9.__________________________________

10.__________________________________

Surgeries/Hospitalizations: Date

1.______________________________ ___________
2.______________________________ ___________
3.______________________________ ___________
4.______________________________ ___________

Date

5.______________________________ ___________
6.______________________________ ___________
7.______________________________ ___________
8.______________________________ ___________

Pregnancies (include miscarriages & abortions)

#	**Date**	**Vaginal or C-section**	**Sex**	**Wks**	**Complications / episiotomy? or injury?**	**Birth Weight**	**Child Alive Today?**	**Child's Name**	**Delivering Doctor**
1									
2									
3									
4									
5									

Have you ever smoked? ❒ Yes ❒ No
How many packs per day? _____________

Do you currently smoke? ❒ Yes ❒ No
How long? ______________

Family History: Family member / Type of Problem / Maternal/Paternal

Cancer (what type) ______________________ __________________________ _______________
Diabetes ______________________ __________________________ _______________
Depression ______________________ __________________________ _______________
Heart Problems ______________________ __________________________ _______________
High Blood Pressure ______________________ __________________________ _______________
Stroke ______________________ __________________________ _______________
Birth Defects ______________________ __________________________ _______________
High Cholesterol ______________________ __________________________ _______________
Genetic Disorders ______________________ __________________________ _______________
Bleeding Problems ______________________ __________________________ _______________
Check if adopted _____

*****Thank you for taking the time to fill out the history paperwork!