Physicians Primary Care of Southwest Florida

Patient History-ObGyn

Patient Name: ____ **Patient DOB:** ___________________

Reason for Today's Visit:____

Medical Problems - Please list or check **current** medical problems:

____Diabetes ____PID (Pelvic Inflammatory Disease) ____Thyroid Problems ____Pelvic Pain ____Hypertension

____GERD ____STD's ____Menstrual Problems ____Incontinence ____Menopausal Symptoms ____PMS

____Abnormal Pap Smears ____Abnormal Bleeding ____High Cholesterol ____Sexual Concerns

Other: ____

____

Please list **past** medical problems:

____Breast Cancer ____Uterine Cancer ____Cervical Cancer ____Ovarian Cancer

Other: ____

Hospitalizations/Surgeries - List all Hospitalizations/ Surgeries (including dates)

_____Cholecystectomy (Gallbladder) _____Appendectomy (Appendix) _____Bladder Repair _____Tubal Ligation

_____Hernia Repair _____Laparoscopy _____Breast Surgery _____Hysterectomy (Total or Partial) _____C-Section

_____Ovary or Tube Removal _____LEEP/Cone Biopsy _____Tonsillectomy _____Back Surgery _____Neck Surgery

_____Cryotherapy

Other: ____

____

Allergies - List Allergies and Reactions

____

____

Family History

	Age	Alive or Deceased	All Health Problems/ Cause of Death
Father:			
Mother:			
Brother's:			
Sister's:			
Son's:			
Daughter's:			
Maternal Grandparents:			
Paternal Grandparents:			

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Social History

Marital status: S M D W Separated	Number of pregnancies?
Name of significant other?	Number of living children?
Most recent primary occupation?	Number of miscarriages?
Is it OK to leave test results on your answering machine?	Number of terminations?
If yes, do you prefer your cell or home number?	Number of C-Sections?
Language spoken at home?	Date of last pregnancy?
Last grade completed?	Weight of largest baby?
Do you exercise regularly?	How long was your longest labor?
Do you have a religious preference?	
Do you drink alcohol? If yes, how often and what kind?	**Check any complications of pregnancy:**
Do you drink caffeinated beverages?	Infections: Gestational Diabetes:
If yes, what is your usual drink and how many per day?	Prolonged Labor: Bleeding:
Do you smoke? If yes, how many packs per day?	2 weeks Overdue: Retained Placenta:
How long have you been smoking?	Toxemia (high blood pressure):
If you smoked in the past, when did you quit?	Other:
Have you used recreational drugs?	**Preferred Local Pharmacy:**
What are you using for contraception?	
Do you use seat belts?	**Preferred Mail Order Pharmacy:**
Do you perform self breast exams?	
Have you ever been a victim of abuse?	

General Information	Vaccinations/Immunizations
Date and result of last TB (PPD) test:	Date of last Pneumococcal Vaccine:
Date of last Colonoscopy:	Date of last Influenza (flu) Vaccine:
Date of last DEXA/ bone density scan:	Date of last Tetanus Shot:
Date of last pap smear?	Date of last Gardasil (HPV) Injection:
Date of last mammogram?	Date of last Zostavax (shingles):

Medications- list any medications that you are now taking. (Including non-prescription medications)

Medication Name	Dosage	Times Daily

Menstrual History

First day of last menstrual period________________________________

Age when periods began_______________

Are you still having period's _____________

Length of periods_____________________

Usual length between periods____________

Flow: Regular Moderate Heavy