MedicalCenter Clinic
HEALTHCARE CENTERED AROUND YOU

OB/GYN

Date:__________________

Referring Physician:____________________________

Name:____
(Last) (First) (Middle)

Date of Birth:_________________ **Age:**_______________ **Social Security #:**_________________

Martial Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Address:____
(street) (city) (state) (zip)

Home Phone:_______________ **Work Phone:** _______________**Cell Phone:**________________

Occupation:_ ____ **Employer:**_________________

Address of Employer:____
(street) (city) (state) (zip)

MEDICAL INSURANCE COMPANY:____

SOCIAL HISTORY: Do you smoke? ☐Yes ☐No If yes, # of pack per day?____________________
Do you consume more than one alcoholic drink per day? ☐Yes ☐No

FAMILY HISTORY: (CHECK ANY ILLNESSES IN FAMILY AND WHICH RELATIONSHIP)

☐ Diabetes- relationship:____

☐ Heart disease- relationship:____

☐ Tuberculosis- relationship: ____

☐ Hepatitis- relationship:____

☐Cancer- relationship: ____

☐ Genetic disease- relationship: ____

OPERATIONS: (CHECK THOSE YOU HAVE HAD, AND THE YEAR)

☐ Removal of uterus……………..(_______________)

☐ Removal of ovaries……………..(_______________)

☐ Removal of cyst or ovary………(_______________)

☐ Cesarean section……………..(_______________)

☐ Tubal ligation………………..(_______________)

☐ Tubal repair………………..(_______________)

☐ Breast surgery………………..(_______________)

☐ Bladder repair………………..(_______________)

☐ Removal of gallbladder………(_______________)

☐ Removal of tonsils……………(_______________)

☐ Heart Surgery………………..(_______________)

☐ Lung Surgery………………..(_______________)

☐ Cone biopsy……………..(______________)
☐ Freezing of cervix……..(______________)
☐ D & C …………………..(______________)
☐ Laparoscopy…………..(______________)
☐ Leep……..……………..(______________)
☐ Other (type)…………..(______________)
☐ Back surgery………………..(______________)
☐ Brain Surgery………………..(______________)
☐ Hernia repair..………………..(______________)
☐ Stomach surgery……………..(______________)
☐ Appendectomy..………………..(______________)

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK APPROPRIATE BOXES)

☐ Heart Disease
☐ High blood pressure
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐Pneumonia
☐ Angina (chest pain)
☐ Kidney disease
☐ Kidney infection
☐ Bladder infection
☐ Bladder dilatations
☐ Tubal infection
☐ Abnormal pap smears
☐ Bleeding problem (menstrual)
☐ Tuberculosis
☐ Epilepsy
☐ Blood transfusion
☐ Hepatitis
☐ Other liver disease
☐ Gallstones
☐ Ulcers of stomach
☐ Ulcers of the intestines
☐ Frequent indigestion
☐ Frequent headaches
☐ Diabetes
☐ Migraine headache
☐ Arthritis
☐ Thrombophlebitis * (clot in leg, legs)
☐ Clots in lungs
☐ Thyroid problems
☐ Cancer

IF YOU ARE STILL HAVING MENSTRUAL CYCLES, ARE THEY: (CHECK ALL THAT APPLY)

☐ Regular
☐ Irregular
☐ Infrequent
☐ Too frequent
☐ Too heavy
☐ Too light
☐ Painful

PRESENT HISTORY: (Reason for visit)
____
____
____

DATE OF LAST MAMMOGRAM: (Reason for visit)________________________________

DEXA / BONE SCAN:____

DATE OF LAST MENSTRUAL PERIOD: (If currently still having periods)________________________

DATE OF LAST PAP SMEAR:____

DATE OF LAST COLONOSCOPY:____

PRESENT METHOD OF BIRTH CONTROL:

☐ None needed
☐ Husband had vasectomy
☐ Birth control pill
☐ Suppositories
☐ Tubal ligation
☐ I.U.D.
☐ Foam
☐ Condoms
☐Rhythm method
☐ Other____
☐ Diaphragm
☐Patch
☐Ring
☐ Injections

TOTAL NUMBER OF PREGNANCIES: (if currently pregnant, count current pregnancy)____

NUMBER OF MISCARRIAGES:____

NUMBER OF PREGNANCY TERMINATIONS:_______________________________________

NUMBER OF CHILDREN BORN LIVE:____

NUMBER OF LIVING CHILDREN:____

ALLERGIES TO:

Foods:____

____

Medications:____

____

PRESENT MEDICATIONS YOU ARE TAKING:_______________________________________

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