CONTEMPORARY OB·GYN

WELCOME TO CONTEMPORARY OB-GYN LTD.

PLEASE FILL OUT THE INITIAL VISIT MEDICAL HISTORY FORM

NAME:	BIRTHDATE: AGE:
PREVIOUS OB/GYN DOCTOR:	TODAY'S DATE:
REFERRED BY:	DATE OF LMP*:

REASON FOR YOUR VISIT: ◯ ROUTINE GYN CARE ◯ PRENATAL / OB CARE

◯ PROBLEM VISIT: Reason _____

*LMP – Last Menstrual Period

HAVE YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST?

MAJOR ILLNESS:	YES	NO	MAJOR ILLNESS:	YES	NO
Anemia			Hepatitis / Jaundice		
Anxiety			Herpes / HSV		
Arthritis / Joint Pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood transfusions			HIV / AIDS		
Breast Cancer			Kidney Infections / Urinary Tract Infections		
Cancer			Kidney Stones		
Chicken Pox			Mood Disorders		
Depression/Bipolar			Sexually Transmitted Diseases		
Diabetes			Thyroid Disease		
Heart Murmur			OTHER:		
Heart Trouble					

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Bone Density		Mammogram	
Colonoscopy Sigmoidoscopy		TB Skin Test	
Flu Shot		Last Normal PAP Smear	
Pneumonia Shot		Last Abnormal PAP Smear	

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS:

SURGERY OR HOSPITALIZATION	DATE
1	
2	
3	
4	

SURGERY OR HOSPITALIZATION	DATE
5	
6	
7	
8	

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN
1		
2		
3		

DRUG NAME	DOSAGE	PHYSICIAN
4		
5		
6		

ANY ALLERGIES TO MEDICATIONS? (LATEX, GLOVES, ETC?) Please List if any:

_____

_____

Are you currently using or have you ever used any birth control? --> ◯ Yes ◯ No

☐ Condoms ☐ NuvaRing ☐ Implanon? Date Inserted: _____

☐ Depo Provera ☐ Birth Control Patch ☐ Natural Family Planning

☐ Diaphragm ☐ Tubal Ligation ☐ Vasectomy

☐ IUD - Name: _____ Date IUD Inserted: _____

☐ Birth Control Pill - Name: _____

Age you had first period: _____

How long does your period last? # of Days:

_____ Flow: --> ◯ Light ◯ Medium ◯ Heavy

Date of Last Period: _____ Are you sure of the date? --> ◯ Yes ◯ No

YOUR OB HISTORY:

	NUMBER		NUMBER
Total # of Pregnancies		Full Term Births	
Premature Delivery (less than 37 weeks)		Abortions / Termination	
Miscarriages		Living Children	

ON THE CHART BELOW, PLEASE FILL IN ANSWERS FOR EACH PREGNANCY INCLUDING MISCARRIAGES:

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight	Sex M/F?	Epid Y/N	Preterm Labor?	Weight Gain	Comments / Problems during Pregnancy&Delivery	Hospital
1										
2										
3										
4										
5										

ANY MAJOR ILLNESSES OF BLOOD RELATIVE? Mother / Father / Brother / Sister

Example: Diabetes - Mother

LIFESTYLE QUESTIONS:

Do you Smoke? ◯ Yes ◯ No ☐ Previously # of Packs per day:_____ # of years:_____

Stopped:_____ How many years ago?:_____

Do you drink Alcohol? ◯ Yes ◯ No Drinks per day:_____ Drinks per week:_____

Any history of abuse? ◯ Yes ◯ No If Yes, please select ☐ Physical ☐ Emotional ☐ Sexual

Patient Signature: **Date:**

_____ _____