OB/GYN- Gary P. Harvey MD

Family and personal health history

Please complete the following information as accurate as possible. If you cannot remember specific details, please give the best estimate. Thank you.

Name:	**DOB:**	**Date:**

Gynecologic History:

Problems with Menstrual Periods?___No ___Yes **Details:** _____

Frequency? (26 days? 28 days?)_____**Date of Last Menstrual Period**_______________

Age of First Period? _____ **Date of Positive Pregnancy Test** _______________

Date of Last Pap____________

History of Abnormal Pap?___No ___Yes **Details:** _____
History of Breast Disease?___No ___Yes **Details:**_____

What is your current method of Contraception?___None___Birth Control Pill___IUD
___ Nexplanon ___Other
Sterilization___No___Yes **Details:**_____

History of Endrometriosis?___No___Yes **What treatments?**_____

History of Infertility?____No____Yes **What tests and/or treatments?**_____

History of Sexually Transmitted Disease?___No ___Chlamydia___Herpes
____ GenitalWarts (HPV) ____Gonorrhea___Other:_____

History of Domestic Violence:____ No ____Yes **Relationship to you:** _____

Obstetric History

Year	City/State	Pregnancy Duration	Hours in Labor	Sex	Birth Weight	Type of Delivery	Complications

Surgical History and Hospitalizations

Year	City/State	Type of Surgery/Reason for Hospitalization	Complications

Health Maintenance

Cholesterol Screening: ___No___Yes **Date**:_____ **Results:** _____
Mammogram:___No___Yes **Date:**_____ **Results:**_____
Colonoscopy:___No___Yes **Date:**_____ **Results:**_____
Bone Density Scan:___No___Yes **Date:**_____ **Results:** _____
Tobacco Use:___No___Yes **Packs per day**_____**Quit?**_____**Date**_______________
Alcohol Use:____No___Yes **Drinks per week**_____
History of Alcohol Abuse:___No___Yes **If yes, details:**_____
Exercise:____**Never**____**1-3 times a week**____**2-4 times a month**
Vitamins and/or Calcium Supplements:___No___Yes
Recreational Drug Use:___No___Yes **Have you used or shared needles?**___No___Yes

Current Medications **No Medications _____**

Medications	Dosage	Frequency	Prescribing Physician

Medical Allergies **No Known Allergies _____**

Medication	Reaction

Personal & Family History: (self, family member, and any details you can remember)

***Are you Adopted?___No___Yes**

History	Family If yes, who?	Self	Details
High Blood Pressure or Vascular Disease (High Cholesterol, Varicose Veins, Blood Clots in Legs)			
Heart Disease (Irregular beats, Heart Attack, Valve Issues, etc.)			
Pulmonary Disease (Asthma, Emphysema ,COPD, TB)			
Diabetes (Type 1 or Type 2, Insulin treatment)			
Thyroid Disease (Underactive, Overactive, Goiters, Graves Disease,)			
Gastrointestinal Disease (Hepatitis, Gallbladder problems, Acid Reflux, Crohns ..)			
Kidney and Bladder Problems (Infections, Stones, Bladder Control Problems)			
Neurological Problems (Migraines, Seizures, Strokes, Paralysis)			
Hematologic (Blood**) Disease** (Anemia, Leukemia, Clotting Problems)			
Musculoskeletal Problems (Arthritis, Joint or Spine problems, Osteoporosis)			
Emotional or Psychiatric Problems (PMS, Anxiety, Depression, Bipolar, Suicide)			
Genetic (inherited**) or Congenital Diseases** (Down Syndrome, Cystic Fibrosis, Hemophilia)			
OTHER Autoimmune disease such as lupus etc.			