

WEST KENDALL OBGYN

MEDICAL HISTORY

Patient Name: _____

Date of Birth: _____

Reason for Visit:

- Gynecology
- Obstetrics
- Urology
- Infertility

Past Medical History (Check any that apply):

- NONE
- Hypertension
- Rheumatology Problem
- Diabetes
- Cholesterol
- Cancer
- Cardiovascular Disease
- Thyroid Disease
- Anemia
- History of Abnormal Pap Smear
- Endocrinology Problems
- Gastroenterology Problems
- Eye Problems
- Urology Problems
- Neurology
- Psychological
- Pulmonary Problems
- Other _____

Gynecological History (Check any that apply):

- NONE
- First day of last period _____
- Age at first Menses _____
- Age at first Child _____
- Age at Menopause _____
- Menstrual Cycle _____
- Duration of Menstrual Cycle _____
- Birth Control Method _____
- Date of Last Pap Smear _____
- Date of Last Mammogram _____
- Date of Last Bone Density _____
- Date of Last Colonoscopy _____
- History of Endometriosis _____
- History of Fibroids _____
- History of Polycystic Ovarian Syndrome _____
- History of Sexually Transmitted Disease _____

Obstetrical History

- NONE
- Total Pregnancies _____
- Spontaneous Abortion _____
- Full Pregnancies _____
- Ectopic Pregnancies _____
- Twin Pregnancies _____
- Induced Abortions _____
- Premature Deliveries _____
- Living _____

Past Pregnancies

Date of Birth	Number of Fetuses	Weeks at Delivery	Birth Weight	Sex	Delivery Type	Anesthesia	Hospital

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Current Medication (Name & Dosage):

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Allergies and Reaction

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Social History

- Smoking Status: ___ Current ___ Former ___ Never
- Illicit Drugs: ___ Yes ___ No
- Alcohol Intake: ___ Occasional ___ Moderate ___ Heavy ___ None
- Caffeine Intake: ___ Occasional ___ Moderate ___ Heavy ___ None
- Exercise Level: ___ Occasional ___ Moderate ___ Heavy ___ None
- Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Domestic Partner
- Education: ___ High School ___ College ___ Post-Graduate
- Occupation: _____
- Is blood transfusion accepted in case of an emergency?: ___ Yes ___ No
- Religion: _____

Family History (Check any that apply):

- | | |
|---|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cervical _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Ovarian _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Uterine _____ | |

Surgical History (Check any that apply):

- | | |
|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Abdominal Surgery |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Bladder Surgery |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Colposcopy |
| <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> Dilation and Curettage |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Endometrial Ablation |
| <input type="checkbox"/> Ovary Removal | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Tonsillectomy / Adenoids | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> LEEP |
| <input type="checkbox"/> Cardiac Surgery | |