Bestcare
Obstetrics & Gynecology

359 Centre Street Suite 1
Nutley, NJ 07110

PATIENT MEDICAL HISTORY FORM

Today's Date_____

First Name_____ Last Name_____ Date of Birth____/____/____

❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Livings with partner

Referred By: _____

Why have you come to the office today?_____

Is this a New Problem? _____

Please describe your problem including where it is, how severe it is, and how long it has lasted._____

_____

Medical History Have you ever had any of the following?

❑ Anemia	❑ Blood Clots in Lungs/Legs	❑ Pneumonia/Lung Disease	❑ Chicken Pox
❑ Heart Disease/Attack	❑ Gall Bladder Disease	❑ Tuberculosis	❑ Bowel Problems
❑ High Blood Pressure	❑ Liver Disease/Hepatitis	❑ Migraines/Headaches	❑ Sickle Cell Disease
❑ Stroke	❑ Kidney Infections/Stones	❑ Depression/Anxiety	❑ Thyroid Problem
❑ High Cholesterol	❑ Bladder Infections	❑ Drug or Alcohol Problem	❑ Blood Transfusion
❑ Mitral Valve Prolapse	❑ Pelvic Infections	❑ Diabetes	❑ Genetic Condition
❑ Bleeding Problems	❑ Arthritis	❑ Asthma	❑ Eating Disorder
❑ Cancer _____	❑ Epilepsy/Seizures/Convolutions		

❑ Breast Cancer	If yes, at what age _____	❑ Check if both breasts or multiple reoccurrences
❑ Colon Cancer	If yes, at what age _____	❑ Check if multiple reoccurrences
❑ Uterine Cancer	If yes, at what age _____	❑ Check if multiple reoccurrences
❑ Ovarian Cancer	If yes, at what age _____	

List all **medications** you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____ _____

_____ _____ _____ _____

Allergies to medications and or foods_____ ❑ No Known Allergies

Surgical History Please list all surgeries with dates:

_____ _____

_____ _____

Obstetrical History Please list all pregnancies (miscarriages, stillbirths, ectopics (tubal), & abortions)

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Births (less than 37 weeks)		Live Births		Living Children	

Year	M/F	Type of Delivery	Week Pregnant	Weight at Birth	**Problems** (e.g., preterm labor, diabetes, high blood pressure)	Name/Age

Gyn History

Age of first period _____

Age of last period _____

Cycle length: every _____ days

lasting _____ days

Periods are: ❑ Regular ❑ Irregular ❑ Painful ❑ Not really bothersome

Flow is: ❑ Light ❑ Light to moderate ❑ Moderate to heavy ❑ Very heavy

Have you ever had sex? ❑ Yes ❑ No

Are you currently sexually active? ❑ Yes ❑ No

Sexual preference: ❑ Men ❑ Women ❑ Both

New partner(s)? ❑ Yes ❑ No

Number of lifetime partners_____

Method of Birth Control: ❑ Condoms ❑ Pills ❑ Patch ❑ Vaginal Ring ❑ Tubal/Essure ❑ IUD ❑ Partner with vasectomy ❑ Natural family planning ❑ Other ❑ None

Have you ever had any of the following STDs? ❑ Chlamydia ❑ Gonorrhea ❑ Herpes ❑ Never had any ❑ HPV ❑ Syphilis ❑ Trichomonas ❑ HIV ❑ Hepatitis B ❑ Hepatitis C

Have you ever had any of the following? ❑ Fibrocystic breasts ❑ Ovarian cysts ❑ Endometriosis ❑ Uterine fibroids

Do you perform regular breast self examination? ❑ Yes ❑ No

Date of last pap smear_____ ❑ Normal ❑ Abnormal

Have you ever needed any of the following for an abnormal pap? ❑ Colposcopy ❑ Cryosurgery ❑ LEEP/Laser/Conization ❑ No

Date of last mammogram _____ ❑ Normal ❑ Abnormal ❑ Never had one

Date of last bone density _____ ❑ Normal ❑ Osteopenia ❑ Osteoporosis ❑ Never had one

Date of last colonoscopy_____ ❑ Never had one

Family History Please list any close relatives with a history of the following:

- ❑ Breast Cancer If yes, at what age _____ ❑ Check if Both Breasts or multiple reoccurrences
- ❑ Colon Cancer If yes, at what age _____ ❑ Check if multiple reoccurrences
- ❑ Uterine Cancer If yes, at what age _____ ❑ Check if multiple reoccurrences
- ❑ Ovarian Cancer If yes, at what age _____

	Relative		Relative
❑Alzheimer's		❑High Blood Pressure	
❑High Cholesterol		❑Diabetes	
❑Mental Illness/ Depression		❑Heart Disease (heart attack Stroke, bypass surgery)	
❑Osteoporosis		❑Other _____	

Social History

Seat Belt Use	❑ Yes	❑ No	
Alcohol Use	❑ Yes	❑ No	If yes, _____drink(s) per day/week/month
Tobacco Use	❑ Yes	❑ No	If yes, _____ pack(s) per day for _____ years
Drug Use	❑ Yes	❑ No	Type and frequency_____
Exercise	❑ Yes	❑ No	Type and frequency_____
Caffeine	❑ Yes	❑ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week
Sexual Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑Yes ❑No Counseling? ❑Yes ❑No
Physical Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑Yes ❑No Counseling? ❑Yes ❑No
Emotional Abuse	❑ Yes	❑ No	If yes, are you safe now? ❑Yes ❑No Counseling? ❑Yes ❑No

Review of Systems Do you currently have any of the following?

	Comments		Comments
❑Yes ❑No Generally healthy		❑Yes ❑No Frequent urination	
❑Yes ❑No Recent weight gain or loss of 25 lbs.		❑Yes ❑No Burning with urination	
❑Yes ❑No Fever		❑Yes ❑No Incontinence	
❑Yes ❑No Vision problems		❑Yes ❑No Urgency	
❑Yes ❑No Sinus problems		❑Yes ❑No Bladder infection	
❑Yes ❑No Hearing loss		❑Yes ❑No Stomach pains	
❑Yes ❑No Chest pain		❑Yes ❑No Vaginal discharge	
❑Yes ❑No Varicose veins		❑Yes ❑No Irreg vagina bleeding	
❑Yes ❑No Shortness of breath		❑Yes ❑No Pelvic pain	
❑Yes ❑No Chronic cough		❑Yes ❑No Painful intercourse	
❑Yes ❑No Diarrhea		❑Yes ❑No Breast lumps	
❑Yes ❑No Constipation		❑Yes ❑No Back pain	
❑Yes ❑No Blood in stools		❑Yes ❑No Joint/muscle pain	
❑Yes ❑No Heartburn/reflux		❑Yes ❑No Depression/anxiety	
❑ None of the above		❑ None of the above	

Patient Signature_____ Date_____

Clinician Signature_____ Date_____

Annual Review #2 Clinician Signature_____ Date_____

Annual Review #3 Clinician Signature_____ Date_____

Revised 08/2010