Newport Beach OB/GYN Medical Group, Inc.

Health History Form

Patient Name:		_ Date:	DOB:		
Reason for visit:		_ Primary Care	Primary Care Physician:		
Pharmacy:					
Have you had any of the			oly):		
Abnormal Mammogram	Fibroids – ute	rine	Liver Disease		
Abnormal Pap Smear	Frequent Blad	Ider Infections	Lupus		
Anemia	Genetic Disord	der	Osteopenia		
Arthritis	Genital Herpes	3	Osteoporosis		
Asthma/Emphysema	GERD		Painful Periods		
Blood Transfusion	Headache/Mig	raine	Problems with Anesthesia		
Cancer (type):	Heart Disease		STDs		
Clotting Disorder	High Cholester	rol	Stroke		
Depression	High Blood Pre	essure	Thyroid Disease		
Diabetes Type I or II	Irregular Vagin	al Bleeding	Other:		
Endometriosis	Irritable Bowel	/Colon			
Epilepsy	Kidney Diseas	е			
Your Most Recent:	Date:	Results:			
Pap smear:	***************************************	Industrial Control of the Control of			
HPV test:		***************************************			
Mammogram:	***************************************			<u></u>	
Colonoscopy:	***************************************				
DEXA:	***************************************				
List all Medications:	Dose:	Frequency			
	MANAGEMENT AND ADMINISTRATION OF THE OWNER.				

List all Allergies:	Reaction:				

Date:	List all Surg	geries and Pro	cedure	s:			
Date:					Date:		
Date: Date: Date: Date: Family History: Condition: Family Member: Age Dx Condition: Family Member Age D Breast Cancer DVT/PE/Clots					Date:		
Date: Family History: Condition: Family Member: Age Dx	***************************************				Date:		
Family History: Condition: Family Member: Age Dx Condition: Family Member Age D Breast Cancer			***************************************		Date:		
Condition: Family Member: Age Dx Condition: Family Member Age D Breast Cancer					Date:		
Breast Cancer	Family History	ory:					
Colon Cancer	Condition:	Family Mem	ber:	Age Dx	Condition:	Family Member	Age D
Ovarian Cancer Ulterine Cancer Osteoporosis Thyroid Disease Gynecologic History: Age of first menstruation: How many children have you had? First day of last menstrual period Are they living? NO YES How often do you get your period? Have you had an miscarriage? NO YES How many? How many days do your periods last? Have you had an abortion? NO YES How many? How many total sexual partners? Do you bleed/spot between periods? NO YES Age at first intercourse: Do you have adopted children? NO YES How many? How many total sexual partners? How many sexual partners in the past year? Current method of birth control: Obstetric History (list all deliveries, miscarriages, abortions): Date: # weeks Sex Vag/C-Sect Weight Complications Social History: Marital Status: Single Married Divorced Widowed Domestic Partner Do you drink alcohol? NO YES How much/often? Do you drink alcohol? NO YES Do you use illegal drugs? NO YES What, how often? Do you exercise? NONE 1-2 times/week 3-4 times/week Almost Daily Do you perform monthly Self Breast Exams? NO YES	Breast Cancer	<u> </u>			DVT/PE/Clots	***************************************	
Uterine Cancer	Colon Cancer	***************************************			Heart Disease		
Osteoporosis Thyroid Disease Gynecologic History: Age of first menstruation: Have you ever been pregnant? NO /YES If so, How many times How many children have you had? First day of last menstrual period Are they living? NO YES How many? How often do you get your period? Have you had a miscarriage? NO YES How many? How many days do your periods last? Have you had an abortion? NO YES How many? Do you bleed/spot between periods? NO YES Have you had an ectopic pregnancy? NO YES Age at first intercourse: Do you have adopted children? NO YES How many? Current method of birth control: How many sexual partners in the past year? Current method of birth control: Married Divorced Widowed Domestic Partner Do you currently smoke? NO Former (quit date): YES How much per day? Do you drink alcohol? NO YES How much/often? Do you use illegal drugs? NO YES Do you use illegal drugs? NO YES Do you perform monthly Self Breast Exams? NO YES Are they living? NO YES If so, How many? If yes If you have you had? How many children have you had? Have you had an estorpic? NO YES How many? Have you had an abortion? NO YES How many? Have you had an abortion? NO YES How many? Do you durrently day and partners in the past year? Do you durrently smoke? NO Former (quit date): YES How much per day? Do you use illegal drugs? NO YES Do you use illegal drugs? NO YES Do you greform monthly Self Breast Exams? NO YES	Ovarian Cancer				Diabetes		***************************************
Gynecologic History: Age of first menstruation:	Uterine Cancer			***************************************	Hypertension		·
Age of first menstruation:	Osteoporosis	***************************************			Thyroid Disease		
Menopause? NO YES since age	Gynecologic His	story:					
First day of last menstrual period Are they living? NO YES How often do you get your period? Have you had a miscarriage? NO YES How many? How many days do your periods last? Have you had an abortion? NO YES How many? Do you bleed/spot between periods? NO YES Age at first intercourse: Do you have adopted children? NO YES How many? How many total sexual partners? How many sexual partners in the past year? Current method of birth control: Obstetric History (list all deliveries, miscarriages, abortions): Date: # weeks Sex Vag/C-Sect Weight Complications Social History: Married Divorced Widowed Domestic Partner Do you currently smoke? NO Former (quit date): YES How much per day? Do you drink alcohol? NO YES How much/often? Do you drink alcohol? NO YES What, how often? Do you use illegal drugs? NO YES What, how often? Do you perform monthly Self Breast Exams? NO YES Do you perform monthly Self Breast Exams? NO YES	Age of first menst	truation:		_ Have you ever b	een pregnant? NO /YE	ES If so, How many times_	
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Do you perform monthly Self Breast Exams? NO YES		•	es/week	3-4 tim			
	•					-	-
				n the past or prese	nt? NO	YES	
	Dationt Name:				DOD:		

Please circle any symptoms you are currently having or have recently experienced:

Weight Gain	Diarrhea	Leaking Urine	Frequent Bruising	Bleeding Easily
Weight Loss	Constipation	Vaginal Discharge	Frequent Headaches	Blood in Stools
Heavy Periods	Joint Pain	Breast Lumps	Nipple Discharge	Breast Pain
Chest Pain	Fainting	Shortness of Breath	Nausea/Vomiting	Abdominal Pain
Bloating	Skin Lesions	Change in Moles	Urinary Frequency	Urinary Urgency
Painful Urination	Irregular Periods	Painful Periods	Bleeding btwn Periods	Wheezing
Hot Flashes	Night Sweats	Excess Hair Growth	Painful Intercourse	Cough
Seasonal Allergies Anxie	ety Depression Insor	mnia		
Any other concern	ıs you may have	e, please list below	:	

				f
Patient Name:		- magazing along a god a god a god a serious a god a	DOB:	