OB~GYN
ASSOCIATES

HEALTH HISTORY FORM

Patient Name ______________________ DOB ____________ Date ____________

Pharmacy Name ____________________ Number ____________ Fax Number ____________

Pharmacy Address ______________________________ City ____________

Appointment Date ____________ Reason for your visit ______________________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM **COMPLETELY**.

1. **VITALS:** Height _____ ft _____ in. Weight ________ lbs.
2. **DRUG ALLERGIES:** Please list ALL No Known Allergies ________

   ____

   Food / Environmental Allergies: ______________________
3. **CURRENT MEDICATIONS**

Name	Dosage	How Often per Day?

4. **PAST MEDICAL HISTORY** Patient Denies Past Medical History ________

	Date (Year)	Normal Results?	Details
Last Pap Smear	________	☐Y ☐N	________
Last Mammogram	________	☐Y ☐N	________
Last Colonoscopy	________	☐Y ☐N	________
Last Dexa / Bone Density	________	☐Y ☐N	________

Have you ever had an Abnormal Pap Smear? If yes, explain ______________________

☐Y ☐N Anemia	☐Y ☐N Arthritis	☐Y ☐N Asthma
☐Y ☐N Auto Immune Disorder	☐Y ☐N Blood Disorder	☐Y ☐N Blood Transfusion
☐Y ☐N Bone Fracture	☐Y ☐N Cancer ________	☐Y ☐N Diabetes
☐Y ☐N Endometriosis	☐Y ☐N Gastric Disorder	☐Y ☐N Heart Disease
☐Y ☐N Hepatitis	☐Y ☐N High Blood Pressure	☐Y ☐N High Cholesterol
☐Y ☐N Infertility	☐Y ☐N Kidney / Bladder Problems	☐Y ☐N Seizures
☐Y ☐N Thyroid - Hyper / Hypo	☐Y ☐N Trauma / Abuse	☐Y ☐N Urinary
☐Y ☐N Uterine Fibroids		

STD's:

☐Y ☐N Chlamydia	☐Y ☐N Gonorrhea	☐Y ☐N Herpes
☐Y ☐N HPV	☐Y ☐N Syphilis	☐Y ☐N Trichomonas

Additional: ____

____

____

Continued on back

5. PAST SURGICAL HISTORY

Patient Denies any Surgeries ______

Appendix	☐ Y ☐ N Year ______	Bladder	☐ Y ☐ N Year ______
Breast Biopsy	☐ Y ☐ N Year ______	Breast Implants / Reduction	☐ Y ☐ N Year ______
C-Section	☐ Y ☐ N Year(s) ______	Cosmetic	☐ Y ☐ N Year ______
Gallbladder	☐ Y ☐ N Year ______	D & C	☐ Y ☐ N Year ______
Ovaries	☐ Y ☐ N Year ______	Hysterectomy	☐ Y ☐ N Year ______
Wisdom Teeth	☐ Y ☐ N Year ______	Tubal Ligation	☐ Y ☐ N Year ______

Other ______

6. FAMILY HISTORY

Patient Denies Family History ______

Breast Cancer	☐ Y ☐ N ______	Colon Cancer	☐ Y ☐ N ______
GYN Cancer	☐ Y ☐ N ______	Other Cancer	☐ Y ☐ N ______
Diabetes	☐ Y ☐ N ______	Type ______	
High Blood Pressure	☐ Y ☐ N ______	Heart Disease	☐ Y ☐ N ______
Stroke	☐ Y ☐ N ______	Genetic Disorder	☐ Y ☐ N ______

7. MENSTRUAL HISTORY

Age at 1st period ______ Days between periods ______ Date of LAST period ______

Total days on period ______ Flow: ☐ Light ☐ Medium ☐ Heavy Clot ☐ Y ☐ N

Method of Birth Control ______ Breakthrough Spotting ☐ Y ☐ N

Menopause Status ______ Age at Menopause ______ Hormone Replacement Therapy? ______

8. PREGNANCY DETAILS

Total Pregnancies # ______ Full Term ______ Preterm ______ Ectopic ______

Elective Abortions ______ Spontaneous Abortions ______

Date	Birth Weight	Sex	Type of Delivery	Complications	Location

9. SOCIAL HISTORY

Tobacco (type & amount) ______ If Former Smoker, Date Quit ______

Alcohol (type & amount/week) ______ Occupation ______

Street Drugs (type & amount) ______ Marital Status ______

Education Level ______

SIGNATURE DATE