

OBSTETRICAL MEDICAL HISTORY

Patient Name _____ Date Form Completed _____

PHYSICIAN NOTES

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? Yes No
If yes, please list: _____

2. Please mark any condition that you have or have had in the past:
 Arthritis or Lupus Cancer Fibromyalgia HIV
 Asthma Chicken Pox Group B Strep Hyperactivity
 Bladder or Kidney Infections Depression Headaches Kidney Disease
 Bleeding Disorder Diabetes Heart Problems Migraine Headaches
 Blood Disease Emotional Disorders Hepatitis Thyroid Disorder
 Bowel Disease Epilepsy Herpes Other
 High Blood Pressure

Describe, if needed: _____

3. Please indicate any operations or surgery you have had. _____

4. Please describe any health problems or symptoms you are having at this time: _____

EXPOSURES AFFECTING HEALTH

1. Do you use tobacco? Yes No If yes, how much per day? _____

2. Do you drink alcoholic beverages? Yes No If yes, how often? _____
What type of drink(s)? _____

3. Please list any medications taken since your last period, including over-the-counter medications: _____

4. Please list any drugs used in the past (i.e. cocaine, marijuana, pain medication, meth, etc.):

5. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any other reason to believe you may have been exposed to AIDS?

6. Do you work with chemicals or radiation (i.e. x-rays)? Yes No

7. Are you on a special diet?..... Yes No
If yes, please describe. _____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap Smear? _____ Have you ever had an abnormal Pap Smear? Yes No If yes, when? _____
What was the diagnosis? _____
What was done? _____

2. Have you ever had gonorrhea, chlamydia or pelvic inflammatory disease? Yes No
If yes, when and where were you treated? _____

3. Have you ever had herpes?..... Yes No

4. Did you receive the HPV vaccine (Gardasil)?..... Yes No

5. Do you use contraceptives? Yes No If yes, what type: _____

6. Have you had bladder or kidney infections? Yes No
If yes, what was done? _____

7. Do you have a history of infertility? Yes No If yes, please describe when and treatment received: _____

8. Please list any other concerns you have related to your past health history:

Patient Signature _____ Print Name _____ Date _____

