Nash OB-GYN ASSOCIATES, P.A.

Patient History

Revised 02/12/19

Date: ______________________________ Patient's Name: ____

Medical Doctor's Name: ______________________________ Medical Doctor's Phone #: ______________________________

ALLERGIES:

Are you allergic to any medication: ❑ Yes ❑ No

Name of medication | Reaction: *(rash, itching, shortness of breath, nausea, etc.)*

____ ____

____ ____

____ ____

MEDICATIONS: *(List any medications you are presently taking)*

______________________________ ______________________________ ___________________________

______________________________ ______________________________ ___________________________

______________________________ ______________________________ ___________________________

PERSONAL SURGICAL HISTORY: *(Check any surgical procedures you have undergone and list the date performed)*

❑ Appendectomy ____________________________________
❑ Breast Biopsy Left/Right __________________________
❑ Breast Reduction _________________________________
❑ Breast Augmentation (implants) ___________________
❑ Colonoscopy _____________________________________
❑ C-Section ____ (indicate number)___________________
❑ D & C ____
❑ Endometrial Ablation ______________________________
❑ Gall Bladder _____________________________________
❑ Heart Surgery (type) ______________________________
❑ Hysterectomy Vaginal/Abdominal ___________________
❑ LEEP/Conization ___________________________________
❑ Removal of Ovaries _________________________________
❑ Sterilization_______________________________________
❑ Tonsillectomy _____________________________________
❑ Other ____
❑ Hysterectomy ______________________________________
Reason for Hysterectomy _________________________

PERSONAL MEDICAL HISTORY:

Cancer (indicate type)
- ❑ Breast
- ❑ Cervical
- ❑ Colon
- ❑ Endometrial
- ❑ Lung
- ❑ Ovarian
- ❑ Other _____________

Cardiac (heart)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Attack
- ❑ Mitral Valve Prolapse

Endocrinology
- ❑ Diabetes Mellitus (during pregnancy)
- ❑ Diabetes Mellitus (non-insulin dependent)
- ❑ Diabetes (insulin dependent)
- ❑ Thyroid Problems
  - ❍ Hypothyroidism
  - ❍ Hyperthyroidism
- ❑ Osteoporosis
- ❑ Osteopenia

Gastrointestinal
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Gallbladder Disease
- ❑ GERD (Reflux)
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Liver Disease
- ❑ Hepatitis

Hematology
- ❑ Anemia
- ❑ Blood Clotting Disorder
- ❑ Blood Transfusion
- ❑ DVT (Deep Vein Thrombosis)
- ❑ PE (Pulmonary Embolism/ Clot in Lung)
- ❑ Sickle Cell Disease/Trait

Infectious Disease
- ❑ Chicken Pox
- ❑ Shingles
- ❑ HIV
- ❑ Tuberculosis/ Positive PPD

Neurology
- ❑ Alzheimer's/Dementia
- ❑ Headache/Migraines
- ❑ Numbness in Hands/Feet
- ❑ Seizures/Epilepsy
- ❑ Stroke

Psychiatric
- ❑ ADD/ADHD
- ❑ Anxiety
- ❑ Bipolar Disease
- ❑ Depression
- ❑ Eating Disorder
- ❑ Panic Attacks

Pulmonary
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Seasonal Allergies

Rheumatology
- ❑ Arthritis
- ❑ Autoimmune Disease
- ❑ Fibromyalgia

Urology
- ❑ Frequent Urinary Tract Infections
- ❑ Hematuria (blood in urine)
- ❑ Kidney Disease
- ❑ Kidney Infection
- ❑ Incontinence (bladder leakage)

CONTINUED ON REVERSE SIDE ➤

SOCIAL HISTORY:

Tobacco use currently: ❑ Yes ❑ No How much per day: ______________________________

Tobacco use in the past: ❑ Yes ❑ No If yes, when did you stop smoking: ______________________

Alcohol use: ❑ Yes ❑ No How much per day/week: ______________________________

Drug use: ❑ Yes ❑ No Describe: ______________________________

Exercise: ❑ Light ❑ Moderate ❑ Heavy

Occupation: ______________________________ Education Level Completed: ______________

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Religious Affiliation: ______________

GYN HISTORY:

Date of most recent Pap Smear: ______________

Date of most recent Mammogram: ______________

Date of most recent Bone Density: ______________

Location of most recent Pap Smear: ______________

Location of most recent Mammogram: ______________

Location of most recent Bone Density: ______________

History of: *(Please check all items that apply)*

❑ Abnormal Pap Smear
Describe: ______________
❑ HPV/Genital Warts
❑ Endometriosis
❑ Fibroids

❑ Ovarian Problems
❑ PCOS
❑ Infertility
❑ Bacterial Vaginosis
❑ Yeast Infections

❑ Chlamydia
❑ Gonorrhea
❑ Trichomonas
❑ Herpes Simplex
❑ Syphilis

Are you sexually active? ❑ Yes ❑ No Current birth control method: ______________________

MENSTRUAL HISTORY:

Age started menstrual cycle: __________ Date of last menstrual period: ______________

# of days of bleeding with your period: ______ # of days from start of one period to the start of the next period: ______

Flow is: ❑ mild ❑ moderate ❑ heavy

Menstrual Cramps: ❑ None ❑ Mild ❑ Moderate ❑ Severe Bleed between Periods: ❑ Yes ❑ No

FAMILY MEDICAL HISTORY: *(Please indicate relationship: mother, father sister, brother, grandmother, etc.)*

❑ Cancer (breast/ovarian/uterine/colon/pancreas/other) ______________________________

❑ Depression ______________
❑ Diabetes ______________
❑ Endometriosis ______________
❑ Fibroids ______________
❑ Heart Attack ______________

❑ High Blood Pressure ______________
❑ High Cholesterol ______________
❑ Irritable Bowel ______________
❑ Osteopenia ______________
❑ Osteoporosis ______________

❑ Stomach Ulcer ______________
❑ Stroke ______________
❑ Hypothyroidism ______________
❑ Hyperthyroidism______________
❑ Ulcerative Colitis ______________

IMMUNIZATIONS: *(Please provide the year the immunization was given)*

❑ Hepatitis B ______________________
❑ Flu shot ______________________
❑ Rubella (German Measles) ______________

❑ Varicella (Chicken Pox) ______________
❑ Tetanus (DT) ______________________
❑ Gardasil/HPV ______________________

PREGNANCY HISTORY:

How many times have you been pregnant: ______________ How many deliveries have you had: ______________

# of living children: ______________ # of miscarriages: ______________ # of abortions: ______________

# of Ectopic Pregnancies: __________