Confidential Health History **Walnut Hill OB/Gyn**

Updated 02/06/12

Name:	Age:	Date of Birth:	Today's Date:
Primary Phone Number:	E-mail Address:		
Referring Physician / Person:	Primary Care Provider:		
Preferred Pharmacy Name:	Pharmacy Phone Number:		

Please describe any special problems or symptoms that you would like to discuss.

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Blood Work		Bone Density	
Mammogram		Colonoscopy			

History of abnormal pap? ☐ Yes ☐ No

Would you accept blood products? ☐ Yes ☐ No

☐ Heart EKG: Stress Test:

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relativ **Grandparents:**

X = Yourself M = Mother F = Father S = Sister B = Brother Maternal = MGM or MGF Paternal = PGM or PGF

	You	Family		You	Family
Autoimmune Disease (Lupus, MS, etc.)			Heart Disease		
Alzheimer's			Hemorrhoids		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Bleeding Disorder			Irritable Bowel Syndrome		
Blood Clots in legs			Kidney Disease		
Blood Clots in lungs			Lung Disease, Asthma		
Blood Disorders			Mental Illness, Depression		
Cancer Breast			Migraine Headache		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Seizure Disorder		
Cancers Other			Skin Disorders		
Diabetes			Stroke		
Drug/Alcohol Abuse			Thyroid Disorder		
Frequent Bladder Infections			Tuberculosis		
Gallbladder Disease or Gallstones			Ulcers		
Hearing Problems			Other:		

SURGERIES

Date:	Surgery:	Date:	Surgery:

HOSPITALIZATIONS (Non-Surgical)

Date:	Problem / Diagnosis:	Comments:

CURRENT MEDICATION

List any MEDICATIONS you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

Do you take Calcium? ☐ Yes ☐ No If yes, amount:

Do you take Vitamin D? ☐ Yes ☐ No If yes, amount:

Do you take a Multiple vitamin or Prenatal Vitamin? ☐ Yes ☐ No

Name:	DOB:	Date:

MEDICATION ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any environmental / latex ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date:	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Age period began:	Do you ever have spotting or bleeding in between your periods? ☐ Yes ☐ No
Number of days between periods:	
Length of periods (# of days of bleeding):	Is PMS a problem for you? ☐ Yes ☐ No
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Do you perform self breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every _____ hours

Do your periods regularly affect your life in a negative way? ☐ Yes ☐ No

Method of birth control:

☐ Condoms	☐ Diaphragm	☐ Implanon	☐ Nuva Ring	☐ Post Menopause	☐ Vasectomy
☐ Contraceptive Pills	☐ Essure	☐ IUD	☐ Foam, Jelly, etc	☐ Same Sex Partner	☐ Other:
☐ Depo Provera	☐ Hysterectomy	☐ Not Sexually Active	☐ Patch	☐ Tubal Ligation	☐ None

Are you interested in a different method of birth control? ☐ Yes ☐ No

REPRODUCTIVE PREGNANCY HISTORY

# of times pregnant:	# of term deliveries:	# of deliveries prior to 37 weeks:	# of elective abortions:
# of miscarriages:	# of ectopic pregnancies:	# of multiple births:	# of living children:

PREGNANCY DETAILS # 1			**PREGNANCY DETAILS # 2**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	

PREGNANCY DETAILS # 3			**PREGNANCY DETAILS # 4**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	

SOCIAL HISTORY

Marital Status: ☐ Divorced ☐ Engaged ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed	Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:
Patient Occupation:	Husband / Partner's Occupation:

Do you exercise? ☐ Yes ☐ No	If yes, # of times per week:	Number of children living at home:

Do you / did you ever drink alcohol? ☐ Yes ☐ No	How much per week?	How many drinks a day?	Is alcohol or drug use a problem for you ☐ Yes ☐ No

Do you / did you ever use ☐ Yes ☐ No	If Yes, what type? ☐ Chewing Tobacco ☐ Smoking / Cigarettes	For how many years?	How much per day?	When did you stop? Date:

Do you / did you ever use any recreational drugs or abuse prescription drugs? ☐ Yes ☐ No	If Yes, what type?

☐ Yes ☐ No Have you ever been sexually abused?	☐ Yes ☐ No If you have experienced abuse, have you received counseling?
☐ Yes ☐ No Have you ever been physically abused?	
☐ Yes ☐ No Have you ever been emotionally abused by anyone important to you?	☐ Yes ☐ No Is this something you would like to discuss today?

Name:	Date of Birth:	Today's Date:

REPRODUCTIVE PREGNANCY HISTORY (continued)

PREGNANCY DETAILS # 5			**PREGNANCY DETAILS # 6**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 7			**PREGNANCY DETAILS # 8**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 9			**PREGNANCY DETAILS # 10**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	
PREGNANCY DETAILS # 11			**PREGNANCY DETAILS # 12**		
Date:	Type of delivery:	Complications:	Date:	Type of delivery:	Complications:
# weeks at delivery:	☐ Vaginal		# weeks at delivery:	☐ Vaginal	
Birth weight:	☐ C-section		Birth weight:	☐ C-section	
Sex of child:	☐ Elective abortion		Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage		Name:	☐ Miscarriage	