# Mary Washington
## Obstetrics and Gynecology

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## Patient form

Date:______________________________

Patient Name:______________________________________________________ Date of Birth: ______/ ______ / ______

**Past Medical History** *Please check all that apply*:

- ❑ Abnormal Bleeding
- ❑ Anemia/Hypertension
- ❑ Anxiety/Depression
- ❑ Asthma/Migraines
- ❑ Blood Transfusion/Pelvic Pain
- ❑ Cardiovascular Disease/Sexual Assault
- ❑ Cervical Dysplasia/Stroke
- ❑ Clotting Disorder/Seizures
- ❑ Diabetes/Thyroid Disorder
- ❑ Endometriosis/Traumatic Injury
- ❑ Esophageal Reflux/Varicosities

Please list any other injury/illness:____________________________________________________________________________

_____________________________________________________________________________________________

Have you ever had CANCER? _______ *If yes, when?*________________ Type?____________________________________

**Please list all allergies to medications and reactions: ( ) No allergies**

**Please list all prescription and over-the-counter medications, including herbal supplements:**

| Medications | Dose/Strength | How taken | Times per day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

| Do you currently have or have you ever had any problems with the following: | No | Yes | Date of diagnosis and treatments |
|---|---|---|---|
| High blood pressure | | | |
| Heart problems | | | |
| Thyroid disorder | | | |
| Diabetes | | | |
| Liver problems/Hepatitis | | | |
| Lung problems/Asthma | | | |
| Kidney problems (UTIs, stones) | | | |
| Autoimmune disorder/ Arthritis/Lupus | | | |
| Gynecological problems (STDs, Fibroids, infertiliy, leep, Cervical biopsy, D&C) | | | |
| Psychological problems (depression, anxiety) | | | |
| Neurological problems (stroke, headache, seizure) | | | |
| Other problems? List: | | | |

## Surgical History:

Have you ever had surgery?_________________________ *If yes, list below:*

Date:_______________ Surgery:_________________________________________

Problems:_________________________________________________________

## Family Health History *Please check all that apply*:

- ❑ Birth Defects
- ❑ Breast Cancer
- ❑ Cardiovascular Disease
- ❑ Clotting Disorders
- ❑ Colon Cancer
- ❑ Diabetes
- ❑ Ovarian Cancer
- ❑ Thyroid Disorder
- ❑ Uterine Cancer

Other:_________________________________________________________

## Reproductive History:

Last Menstrual Period:______________________________

Method of Contraception: ______________________________ Do you desire contraception? ❑ Yes ❑ No

Total Pregnancies: __________ Full Term:__________ Pre-Term (under 38 weeks):__________

Miscarriages: __________ Abortions:__________ Ectopic: __________ Stillborn: __________

C-Section: __________ Current living children: ________

**Problems during previous pregnancies (check):**

Hypertension: __________ Diabetes: __________ Toxemia: __________ Pre-Term Labor:____________

Excessive Blood Loss: __________ Blood Transfusion: ______________

## General Health: *Please check all that apply*:

Alcohol Use: ❑ Neve ❑ Rarely ❑ Occasionally ❑ Moderately

Tobacco Use: ❑ Never ❑ Former ❑ Current Packs per day: ________________

Date of last Pap Smear:________________

Date of last Mammogram: ______________

Date of last Colonoscopy: ______________

Date of last Bone Density: ______________

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