Obstetrical Associates CM_____

Patient History Form

Name:_____ Maiden:_____ Spouse:_____
Address:_____ City, State:_____ Age:_____
Zip:_____ DOB: / / Age:_____ SS#:___ - ___ - ____ SS#:___ - ___ - ____
Phone: (H) ( )_____ (W) ( )_____ Occupation:_____
Occupation:_____ Employer:_____ Phone: (W) ( )_____
Insurance:_____ Primary MD:_____ Insurance:_____

I. Allergies

Do You Have Allergies? ☐ Yes ☐ No (Please √ appropriate box(es) below and list reaction(s) in the spaces provided.

Medication	Reaction	Medication	Reaction	Medication	Reaction	Medication	Reaction
☐ Penicillin		☐ Codeine		☐ Shellfish		☐ Latex	
☐ Sulfa		☐ Aspirin		☐ X Ray Dye		☐ Other:	

II. Family History (√ as Appropriate)

Family Member	Diabetes	Heart Disease	Stroke	Hypertension	Osteoporosis	Endometriosis	Other				Cancer:	Breast	Ovary	Uterus	Cervix	Colon	Bladder	Other				
1	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐		☐	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐

III. Personal Medical History

☐ **None** ☐ Heart Failure ☐ High Blood Pressure ☐ Thyroid Disease ☐ Depression
☐ Asthma ☐ Angina ☐ High Cholesterol ☐ Osteoporosis ☐ Anxiety
☐ Heart Attack ☐ Stroke ☐ Diabetes ☐ Bladder Infections ☐ Cancer:_____
☐ Other:_____

IV. Personal Surgical History

☐ **None** ☐ Breast Biopsy R L ☐ Tubal Ligation ☐ Cesarean Section #:_____
☐ Gallbladder ☐ Mastectomy R L ☐ Ovarian Removal R L ☐ Surgery for Endometriosis
☐ Appendectomy ☐ Breast Implants R L ☐ Ovarian Cystectomy R L ☐ Blood Transfusion Year:_____
☐ Tonsils ☐ Ectopic Pregnancy R L ☐ Vaginal Repair Reaction? ☐ Yes ☐ No
☐ D & C ☐ Hysterectomy ☐ Bladder Repair ☐ Reaction to Anesthesia
☐ Other:_____

V. GYN History

Age of First Period:_____ Cycle Frequency:_____
Cycle Duration:_____ Flow: Heavy Med Light
Pregnancies:_____ # Deliveries (>37 wks):_____
Preterm (<37 wks):_____ # Miscarriages:_____
Abortions:_____ # Living Children:_____

☐ Endometriosis ☐ Recurrent Yeast Infections
☐ Gonorrhea ☐ Chlamydia ☐ Herpes

VI. Social History

Tobacco Use? ☐ Yes ☐ No # Packs/Day:_____ # Years:_____
Alcohol Use? ☐ Yes ☐ No ☐ Social # Drinks/Day:_____
Are You Sexually Active? ☐ Yes ☐ No # Partners in Last Year:_____
Do You Use Contraception? ☐ Yes ☐ No Type:_____
History of Abnormal Pap? ☐ Yes ☐ No When: /
History of Abnormal Mammogram? ☐ Yes ☐ No When: /
Are you in a relationship where you are hurt, hit, threatened or afraid? Yes No

VII. Medications

Medication	Dose	Frequency	Medication	Dose	Frequency
1			5		
2			6		
3			7		
4			8		

Date Reviewed_____ _____ NP/MD

MA Initials_____

Please Complete the Other Side →