HAHN OB/GYN ASSOCIATES

NAME_____ DOB _____Chart#_____

Reason for Visit_____

Height_____ Weight_____Blood Pressure_____Pharmacy_Name& #_____

Primary Care Physician_____Phone #_____

Medical History (please answer as completely as possible)

Have you ever used illicit drugs, alcohol, or do you smoke? If yes to any of the above, How much and for how long?

_____

_____

What Medications do you take and the dosage? (Can attach a list)

_____

_____

Allergies to medications? _____

Type of reaction (i.e. rash, trouble breathing) _____

Environmental Allergies_____

Have you had any surgeries or hospitalizations? Type of surgery and when _____

_____

_____

_____

Last Period_____Regular Periods? _____ Any STD's_____ Type of Birth control used_____
Urinary problems? _____Last Pap_____Last Mammogram_____Bone Density_____

Number of pregnancies? _____ Live Births_____ Living Children_____Miscarriages_____

Do you have any personal history of High Blood pressure, Heart disease, Lung problems, Thyroid Disease, Diabetes or Cancer or any other condition? Please list

_____

_____

_____

Any Family History of the above Conditions and who?_____

_____

_____

Is there any other Medical condition we should be aware of? _____

_____