DOTHAN OBGYN, INC.

NAME: ___________________________________ DOB: __________________ DATE: _____________________

PLEASE COMPLETE THE FOLLOWING INFORMATION TO THE BEST OF YOUR KNOWLEDGE. THANK YOU !

REASON FOR VISIT TODAY:

_____ Screening Health Exam and Pap smear (Annual Exam)

_____ Pregnancy – Initial prenatal care appointment

_____ Problem visit or other reason: ____

PATIENT HISTORY

_____ No medical problems to report

_____ Abnormal Pap smear

_____ Cancer

_____ Diabetes

_____ Endocrine disorder (or related disease)

_____ Heart disease

_____ Hypertension (Blood Pressure disorder)

_____ Last Pap Smear Year/Result ____________________

_____ Last Mammogram Year/Result ___________________

_____ Bone Density Year/Result ______________________

_____ Colonoscopy Year/Result ______________________

_____ Kidney Disease (or related urologic disorder)

_____ Liver Disease (or related disorder)

_____ Infection (Sexually transmitted or other-Current/Past)

EXPLAIN: ____

____

PAST SURGICAL HISTORY

_____ No Surgeries to report

_____ Hysterectomy

_____ Appendectomy (appendix removed)

_____ Cholecystectomy (gall bladder removed)

_____ Eye/Ear Surgery

_____ Heart Surgery

_____ Hernia Repair

_____ Joint Surgery

_____ Kidney Surgery

_____ Neck/Pain Surgery

_____ Oral Surgery

_____ Sinus Surgery

_____ Tubal Ligation Surgery

_____ Endometrial Ablation

_____ Cesarean Section

EXPLAIN: ____

____

MEDICATION LIST: Please write names and doses of medications you are currently taking:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

ALLERGY LIST

_____ No known allergies _____ Latex _____ IVP Dye

_____ Penicillin _____ Iodine _____ Other

_____ Sulfur drugs _____ Shell fish

EXPLAIN: ____

FAMILY HISTORY

_____ No family medical diseases to report _____ Hypertension (Blood pressure disorder)

_____ Breast Cancer _____ Kidney Disease (or related disorder)

_____ Other Cancer _____ Liver Disease (or related disorder)

_____ Endocrine Disorder(s) _____ Diabetes

_____ Heart Disease _____ Other

EXPLAIN: ____

____

REPRODUCTIVE HISTORY MENSTRUAL

_____ Stopped periods _____ Pregnant _____ Unknown Cause _____ Menopausal

First day of last Menstrual Period: ______________________ Age when period started: ____________________

Menstrual Flow: _____ Heavy _____ Medium _____ Light

Current birth control method: _____ Pills _____ Tubal Ligation _____ Other: ___________________________

If you are having periods, are they: _____ Regular _____ Irregular How long does bleeding last? _____________

How many days from the start of a period to the start of the next period? _________________________________

EXPLAIN: ____

PREGNANCY HISTORY

TOTAL PREG ____ FULL TERM ____ PREMATURE ____ ABORTIONS ____ MISCARRIAGES ____ ECTOPIC ____ TWIN PREG ____ LIVING CHILDREN ___

DELIVERY INFORMATION

DETAILS (PLEASE COMPLETE. IF NECESSARY, USE THE BACK OF SHEET)

NUMBER	DATE	# WEEKS AT DEL	HRS IN LABOR	BIRTH WT	SEX	DEL TYPE	ANESTHESIA	COMPLICATIONS	STATE
Example	2/15/2011	38 wks.	12 hours	7 lbs	M	Vaginal	Epidural	Blood pressure	AL
1									
2									
3									
4									
5									

SOCIAL HISTORY (Please circle)

Marital Status: Married Divorced Engaged Separated Single Widowed

Substance Use: Alcohol: Never Everyday In the past Occasionally

Tobacco: Never Everyday In the past Occasionally

Drug Use: Never Everyday In the past Occasionally

DOMESTIC VIOLENCE

_____ No issues _____ Need to discuss with provider

RELIGION Do you accept blood products ? _____ Yes ______ No

SEXUAL HISTORY (indicated for risk assessment) **Age of first sexual intercourse**: ____

Greater than 5 sexual partners? _______ Yes ________ No

REVIEW OF SYSTEMS: (Mark any of the following that you have had in the **past 30 days**)

CONSTITUTIONAL: ____ Fatigue _____ Fever _____ Headaches

BREAST: ____ Lumps **CARDIO**: _____ Chest Pain **RESPIRATORY**: ____ Shortness of breath with exercise

GASTRO: _____ Blood in stool G**ENITOURINARY**: ______ Incontinence **INTEGUMENT**: _______ New skin lesions

ENDOCRINE: _____ Weight Loss _____ Weight gain **PSYCHIATRIC:** _______ Suicidal Ideation

HEME-LYMPH: ______ Easy bleeding

OTHER CONCERNS: ____