North Florida OB GYN, LLC– BAPTIST III

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(Please fill out all information to the best of your ability) **Date:_____**

Patient's Name:_____ DOB: _____/_____/_____ Age:_____ Race:_____

Referred by: _____ Primary Care Physician: _____

Reason for Appt:_____ Pharmacy:_____
(Local and Mail Order)

Allergy/Reaction:_____
Please list anything you are allergic to and the reaction it causes .(MEDICATION AND CONTACT ALLERGIES INCLUDED)

Medication & Dosage:_____
Vaccinations: FLU VACCINE_____ TETANUS____HEPATITIS SERIES____ HPV VACCINE____ PNUEMOVAX_____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

Y N Have you ever had a blood transfusion?
Y N Are you willing to have a blood transfusion to save your life?
Y N Ever had an abnormal Pap Smear? If yes, treatment_____ Year:_____

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea
Y N Kidney/Bladder Problem	**Y N** Fibroids	**Y N** Blood Disorders/Clots	**Y N** Hepatitis
Y N High Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Low Blood Pressure	**Y N** Depression	**Y N** Hemorrhoids	**Y N** Genital Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Stomach Trouble	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome	**Cancer:** _____
Y N Ulcer	**Y N** Anxiety	**Y N** Chlamydia	**Other:** _____

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History**:** ___ #OF PREGNANCIES___ #LIVE BIRTHS___#MISCARRIAGES___#ABORTIONS___#LIVING CHILDREN

Date	Delivery Type (vaginal/cesarean)	Wks	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease. Who?_____
Y N High Blood Pressure. Who:_____
Y N High Cholesterol. Who?_____
Y N Blood Disorder. Who?_____
Y N Diabetes. Who?_____
Y N Thyroid Disease. Who?_____

Other Significant Family History:_____

Social History

Marital History: Single/Married/Separated/Divorced/Widowed		
Use of alcohol: **Never/Daily/Moderate/Social/Rare**	Use of tobacco: **Never/Current/Past ____ ppd**	Use of drugs: **Never/Past/Current**
Hx of domestic violence: **Y N**	Sexually active: **Y N**	Birth control method:_____
1st Day of Last Period:____ Cycle Length: ___days # of days bleeding ___ Flow: light/ moderate/heavy		

Last Pap:_____ Last Mammogram:_____ Last Bone Density:_____ Last Colonoscopy:_____