North Florida OB GYN, LLC.

Patient's Name______________________________________ **DOB:** _____/_____/______ **Date:** ____________
Age:________ **Race** ________ **Ethnicity**___________**Language**______________

Referred by: ____
Reason for this Appt____

Primary Care Doctor: __________________**Preferred Pharmacy: name/street/location**____________________

Last Pap Smear/Date:__________Normal _____Abnormal_____
Last Mammogram/Date:________Normal_____Abnormal____
Last Bone Density/Date:________Normal_____Abnormal____
Last Colonoscopy/Date:_________Normal_____ Abnormal_____

Family History: Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
Heart Disease		Birth Defect		**Cancer**	
High Blood Pressure		Blood Clots		Breast/Age	
High Cholesterol		Diabetes		Melanoma	
Stroke		Kidney Problems		Ovarian	
Depression / Suicide		Thyroid		Colon	
Alzheimer's / Dementia		Osteoporosis		Other	

Medical Allergies

Item	Reaction

Current Medication

Drug	Dose	How Often

Current Medication

Drug	Dose	How Often

Past Medical History: Have you ever had any of the following illnesses? Check all that apply.

Heart Trouble
Kidney / Bladder Problems
High Blood Pressure
Low Blood Pressure
Hypothyroidism
Hyperthyroidism
Migraine Headaches
Rectal Bleeding
Stomach Trouble /Ulcer/ IBS

Osteoporosis
DES exposure
Dysplasia / HPV
Fibroids
Pelvic Prolapse
Depression
Endometriosis
Seizures

Chronic Fatigue
Anemia
High Cholesterol
Hepatitis
Anxiety
Varicose Veins
Diabetes
Blood Disorders

Breast Problems / Nipple Discharge
Hemorrhoids
Anesthesia Problems
Heart Murmur / MVP
Polycystic ovarian syndrome
Genital Herpes /Genital Warts
Cancer (type) _________________
STD type______________________
Other ________________________

Social History: Use of alcohol Never Occasional Moderate Daily **Illegal Drugs** Yes No

Tobacco Use: Never Smoked Current Smoker Former Smoker

Surgical History: (Including Hospitalizations)

Date	Procedure

of **Pregnancies** _____ **Miscarriages** ____ **Abortions** _____

Date	Delivery Type	Sex	Lbs/Oz	Complications