North Florida OB GYN, LLC

Beaches OBGYN Office
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(Please fill out all information to the best of your ability) **Date:** ___________________

Patient's Name: _______________________________________ **Marital Status:** ________ **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.)

Medications & Dosages: ____

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(s):_______________

Y N Heart Trouble
Y N Osteoporosis
Y N Diabetes
Y N Gonorrhea/Chlamydia
Y N Kidney/Bladder Problems -or- Urinary Incontinence
Y N Fibroids
Y N Bleeding Disorders/Blood Clots
Y N Hepatitis
Y N **High** or **Low** Blood Pressure
Y N Pelvic Prolapse
Y N Breast Discharge/Problem
Y N HIV
Y N Migraine Headaches
Y N Depression/Anxiety
Y N Hemorrhoids
Y N 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 Ulcer
Y N Anemia
Y N Antibiotic for dental work
Y N HPV
Y N IBS
Y N High Cholesterol
Y N Polycystic Ovarian Syndrome (PCOS)
Y N Abnormal Mammo
Y N Infertility
Y N Anxiety
Y N Ovarian Cysts
History of Cancer:_____________

Mo/Yr	ILLNESSES or OPERATIONS	Complications YES or NO

Obstetrical History
Please list the number of:

Premature Births__________ Miscarriages_______________

Abortions ___________ Times Pregnant ___________

Living Children_________________

Pregnancy History: Please list all pregnancies (including: ectopic/miscarriage/abortion).

Date	Delivery Type (vaginal/cesarean)	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
Y N High Blood Pressure
Y N High Cholesterol
Y N Blood Disorder
Y N Diabetes
Y N Thyroid Disease

Other Significant Family History:____

Social History

Use of alcohol: **Never/Daily/Moderate**

Drug use: **Y N**

Tobacco Use: Have you ever smoked? Y N
Current Smoker: ______packs per day OR
Former Smoker: quit date___________.
Sexually active: **Y N** Birth control method:____

History of Domestic Violence: **Y N**

Last Pap: ___________ (Date) **Last Mammogram:** ___________ (Date) **Last Bone Density:** ___________ (Date) **Last Colonoscopy:** ___________ (Date)