MEDICAL HISTORY FORM – Please answer all questions or mark N/A if non-applicable to you.

Patient Name: _________________________________ **Date of Birth:** _____________________

Race – Specify: ________________________________ **Date:** ____________________________

ALLERGIES: **Do you have any drug allergies? Yes / No List all allergies and reaction to each.**			
Drug	**Reaction**	**Drug**	**Reaction**
Do you have any allergies to :	Latex Yes / No	Reaction:	
	IV Contrast Yes / No	Reaction:	
	Iodine Yes / No	Reaction:	

Y / N | Are you willing to have a blood transfusion in order to save your life?

MEDICATIONS: **Please list all medications, including all Over the Counter Medications. Continue on back if necessary.**

Drug	Dosage (mg)	Number of times taken per day	Drug	Dosage (mg)	Number of times taken per day

SOCIAL HISTORY: **Please circle "Y" or "N", fill in the blanks, and check boxes.**			
Y / N	Alcohol – Type:	Amount per day:	
Y / N	Tobacco – Type:	Amount per day:	Quit: Year :_______
Y / N	Steroids, Illegal drugs – Type:	Amount per day:	
Y / N	Special diet (circle): Diabetic, Weight Watchers, Atkins, Sugar Busters, Other (specify)		
	Religion		
	Marital History: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed		
	Living situation: ☐ alone ☐ with spouse ☐ with partner ☐ with parents / custodian ☐ with children ☐ at school ☐ other		

Current birth control method (circle): Abstinence / Pill / Patch / Ring / Shot / Condom / Partner has vasectomy / Essure
IUD: Type________ Year______ / Tubal ligation / Hysterectomy: Year______ / Natural Family Planning / Post Menopausal: Year_____

Condom use: ☐ always ☐ most of the time ☐ rarely ☐ never

Abuse and Domestic Violence History	
Y / N	As a child or teen, were you sexually abused or molested?
Y / N	As an adult, were you sexually abused or molested?
Y / N	Are you currently being sexually abused, threatened or hurt by anyone?

HEALTH SCREENING:

Last Pap Smear Year_________ ☐ Normal ☐ Abnormal ___________________________________

Last Mammogram Year_________ ☐ Normal ☐ Abnormal ___________________________________

Last Bone Density Year_________ ☐ Normal ☐ Abnormal ___________________________________

Last Colonoscopy Year_________ ☐ Normal ☐ Abnormal ___________________________________

SURGICAL HISTORY: **When appropriate, please indicate Right or Left and location.**

Date	Surgical Procedure	Date	Surgical Procedure

PREGNANCIES: (Including Miscarriages) **List all dates of pregnancies including Miscarriages and Abortions**

of Pregnancies: _____ #Premature Births: _____ # Miscarriages: _____ # Abortions ______ # Living Children: _____

Month/Year Born	Baby's Sex	Weight at Birth	Weeks Pregnant	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications
		Lbs oz					
		Lbs oz					
		Lbs oz					
		Lbs oz					
		Lbs oz					
		Lbs oz					
		Lbs oz					

PERSONAL MEDICAL HISTORY: **Please indicate if you have been diagnosed with any of the condition(s) listed below.**

Condition:	✓	When Diagnosed	Condition:	✓	When Diagnosed
Heart disease			Kidney problems		
High blood pressure			Osteoporosis		
High cholesterol			Cancer (type): Breast (age)		
Stroke			Melanoma (location)		
Depression			Ovarian		
Suicide attempt			Colon		
Alzheimer's / Dementia			Other (Please specify):		
Free bleeder			Anesthesia problems (describe)		
Birth defect			Alcohol / Drug abuse		
Blood clots in legs or lungs			Thyroid Disorder (Hypo / Hyper / Goiter)		
Abnormal Pap Smear			Diabetes		
HIV/AIDS			OTHER (SPECIFY)		
Sexually Trans Diseases (Type) :____________					

FAMILY HISTORY: **Please indicate which of your family members have had the following condition(s).**

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Heart Disease										
High Blood Pressure										
Diabetes										
Stroke										
Cholesterol										
Other Cancer Please Specify:										
Other Please Specify:										

I attest that this medical health history is true, accurate, and complete. Further I understand that ANY omissions, falsifications, or otherwise incorrect information that I provide, regardless of the reason, may directly affect my medical care and increase my risk of complications. I acknowledge that I can be discharged from North Florida OB/GYN, if North Florida OB/GYN determines that this attestation is untrue, inaccurate, or incomplete. I agree to accept full and complete responsibility to inform North Florida OB/GYN of any changes in my medical history that occur while I am under the care of North Florida OB/GYN.

Patient's name (Please Print):___________________________________ Date of Birth:________________________

Patient's Signature:____ Date of Signature:____________________

Completed by: (if other than patient):_______________________________ Relationship:________________________