

North Florida OB GYN, LLC

Nassau County Division

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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 & Dosage: _____

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

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

Date	Procedure

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
Y N Breast Cancer		Heart Disease. Who? _____
Y N Uterine Cancer		High Blood Pressure. Who? _____
Y N Skin Cancer		High Cholesterol. Who? _____
Y N Ovarian Cancer		Blood Disorder. Who? _____
Y N Colon Cancer		Diabetes. Who? _____
		Thyroid Disease. Who? _____

Other Significant Family History: _____

Social History

Use of alcohol: **Never/Daily/Moderate** Use of tobacco: **Y N** _____ packs per day Use of drugs: **Y N**

Hx of domestic violence: **Y N** Sexually active: **Y N** Birth control method: _____

Last Pap: _____ **Last Mammogram:** _____ **Last Bone Density:** _____ **Last Menstrual Period:** _____

Last Colonoscopy: _____ **Last Flu Shot:** _____ **Last Pneumo Vaccine:** _____