North Florida OB GYN, LLC

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Patient's Name_____ **DOB:** _____/_____/_____ **Date:** _____

Age:_____ **Race** _____ **Referred by:** _____ **Last Period** _____ **Age of onset** ___ **Regular** yes no

Cycle Length ___ **days (from start to start) Duration** _____ **days Post menopausal** yes no

Reason for this Appt_____ **Current birth control method Name of birth control**_____

PCP: _____ **Preferred Pharmacy and Ph#:** _____

Last Mammogram: _____**Last Bone Density:**_____ **Last Colonoscopy**:_____

Have you ever had an abnormal pap? ____ yes ____ no Date: _____Treatment: _____

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

Allergies

Item	Reaction

Medication

Drug	Dose	How Often

Medication

Drug	Dose	How Often

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

Heart Trouble
Kidney / Bladder Problems
High Blood Pressure
Low Blood Pressure
Thyroid Problems
Migraine Headaches
IBS
Ulcer
Stomach Trouble
Osteoporosis
DES exposure
Rectal Bleeding
Fibroids
Pelvic Prolapse
Depression
Endometriosis
Seizures
Chronic Fatigue
Anemia
Cholesterol
Hepatitis
Anxiety
Varicose Veins
Diabetes
Breast Problems / Nipple Discharge
Hemorrhoids
Anesthesia Problems
Heart Murmur / MVP
Antibiotics for Dental work
Polycystic ovarian syndrome
Blood Disorders
Cancer (type) _____
Other _____

STD type **Chlamydia Gonorrhea Hepatitis HIV Genital Warts Genital Herpes Syphilis HPV**

Have you ever had a blood transfusion? Yes No

Are you willing to have a blood transfusion in order to save your life? Yes No

Surgical History: (Including Hospitalizations)

Date	Procedure

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

Date	Delivery Type	Sex	Lbs/Oz	Complications

Social History: **Use of alcohol** Never Daily Moderate **Cigarettes**_____ packs per day **Drugs** Yes No