NORTH FLORIDA OB/GYN, LLC

Nassau Division

DATE_____/_____/_____

FIRST NAME_____ LAST NAME_____ MI____ DOB___ /___/___ AGE ___
DAYTIME#_____ ALTERNATIVE#_____RACE_____

REASON FOR THIS APPOINTMENT_____

TOTAL PREGNANCIES: _____ FULL TERM_____ PRETERM_____MISCARRIAGES_____ABORTIONS_____ LIVING_____

Date	Delivery Type	Sex	Lbs./Oz	Complications

MENSTRUAL HISTORY: LMP:_____

_____X_____X_____X_____

PAP SMEAR HISTORY: LAST PAP_____ [ ] NEVER WAS IT NORMAL? [ ] YES [ ] NO
HAVE YOU EVER HAD AN ABNORMAL PAP? [ ] NO [ ] YES…..WHAT? _____

MAMMOGRAM HISTORY: LAST MAMMOGRAM_____ [ ] NEVER WAS IT NORMAL? [ ] YES [ ] NO
HAVE YOU EVER HAD BREAST PROBLEMS? [ ] NO [ ] YES…..WHAT? _____

BONE DENSITY HISTORY: LAST BONE DENSITY_____ [ ] NEVER WAS IT NORMAL? [ ] YES [ ] NO
IF ABNORMAL WHAT WAS THE RESULT? _____
VACCINATIONS: (When) INFLUENZA_____ GARDASIL_____ PNEUMOVAX_____
MEDICATIONS: (Please list all medications)
_____

PAST MEDICAL HISTORY: Have you ever had the following illnesses? Circle all that apply.

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

DO YOU HAVE ANY ALLERGIES? Yes No (Please list)
_____

Are you allergic to any medications? Yes No (Please List medication and reaction)
_____

_____

SURGICAL HISTORY:

Date	Procedure

SOCIAL HISTORY:
MARITAL STATUS: [ ] MARRIED (HOW LONG_____) [ ] SINGLE [ ] DIVORCED [ ] WIDOWED
USE OF ALCOHOLIC BEVERAGES: HOW MUCH? _____ [ ] DAILY [ ] WEEKLY [ ] MONTHLY [ ] NEVER
DO YOU SMOKE: [ ] NO [ ] YES HOW MANY PER DAY_____ HOW LONG? _____
DO YOU USE ILLEGAL DRUGS? [ ] YES (please specify) _____ [ ] NO
ARE YOU A VICTIM OF ABUSE OR DOMESTIC VIOLENCE? [ ] YES [ ] NO

FAMILY HISTORY: (Has any of your blood relatives had any of the following)

	Family Member		**Family Member**
[ ] DIABETES	_____	[ ] HEART TROUBLE	_____
[ ] HIGH BLOOD PRESSURE	_____	[ ] KIDNEY TROUBLE	_____
[ ] LUNG DISORDER	_____	[ ] CANCER	_____

(Breast, Ovarian, Uterine, Colon, etc.)