

North Florida OB GYN, LLC
ST VINCENT IV
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Patient's Name: _____ **DOB:** ____/____/____ **Date:** _____

Age: _____ **Race:** _____ **Referred by:** _____

Reason for this Appt: _____ **Current birth control method:** _____

Primary Care Physician: _____

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, siblings, or children)

Cancer	
Breast/Age	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?
Uterine	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?
Melanoma	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?
Ovarian	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?
Colon	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?
Other:	<input type="checkbox"/> yes <input type="checkbox"/> no Who/age?

Allergies

Medication

Mediation

Item	Reaction

Drug	Dose	How often

Drug	Dose	How often

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

- | | | | |
|----------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Breast Problems / Nipple Discharge | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney / Bladder Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Anesthesia Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Antibiotics for Dental work |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Heart Murmur / MVP | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Pelvic Prolapse | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> IBS | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Cancer (Type) _____ | | | |

STD type: Chlamydia Gonorrhea Hepatitis 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)

Total Pregnancies _____ **Miscarriages** _____ **Abortions** _____

Date	Procedure

Date	Delivery Type	Sex	Lbs/Oz	Complications

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