St. Augustine OB GYN, LLC

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(Please fill out all information to the best of your ability) **Date:** _____

Patient's Name: _____ **Marital Status:** _____ **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.)

Medications & Dosages: _____

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(s):_____

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea/Chlamydia
Y N Kidney/Bladder Problems -or- Urinary Incontinence	**Y N** Fibroids	**Y N** Bleeding Disorders/Blood Clots	**Y N** Hepatitis
Y N **High** or **Low** Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Migraine Headaches	**Y N** Depression/Anxiety	**Y N** Hemorrhoids	**Y N** Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Ulcer	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome (PCOS)	**Y N** Abnormal Mammo
Y N Infertility	**Y N** Anxiety	**Y N** Ovarian Cysts	**History of Cancer:**_____

Mo/Yr	ILLNESSES or OPERATIONS	Complications YES or NO

Obstetrical History
Please list the number of:

Premature Births_____ Miscarriages_____

Abortions _____ Times Pregnant _____

Living Children_____

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 Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease
Y N High Blood Pressure
Y N High Cholesterol
Y N Blood Disorder
Y N Diabetes
Y N Thyroid Disease

Other Significant Family History:_____

Social History

Use of alcohol: **Never/Daily/Moderate**

Drug use: **Y N**

LMP: _____
Date

Tobacco Use: Have you ever smoked? Y **N**
Current Smoker: _____packs per day OR
Former Smoker: quit date_____.
Sexually active: **Y N** Birth control method:_____

History of Domestic Violence: **Y N**

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