Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ______________________________ Birthdate_________ Age _____ Date____________

| Allergies to medications/food/environment | Reaction |
| --- | --- |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Current Medications (Prescription, over the counter, herbal) | Prescribing Doctor | Dose | Instructions | Reason Used |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

What do you do so you don't become pregnant?
____ Diaphragm ____ Condoms ____ Sponge ____ Rhythm ____ IUD
____ Withdrawal ____ Depo Provera ____ Vasectomy ____ Norplant ____ Pills
____ Essure ____ Tubal Ligation ____ Nexplanon ____ Ortho Evra ____ Nuva Ring
____ Other ____________________________________________________________

First day of last period_______________________________
What age were you when you started your first period? _____________
Are your periods regular? ___________________
Is there bleeding between periods? ___________
How often do your cycles occur? _______________________
For how many days do you bleed? ________________________
Flow is: ______ scant ______ mild ______ mod ______ severe ______ incapacitating
Other symptoms with periods? ______________________________________________________
__________________________________________________________________________________
Date of last pap smear _________________________________
Have you had an abnormal pap smear? No ______ Yes_____
Has this been treated? No ______ Yes_____
How? ______________________________________________________________
Do you examine your breasts regularly? No ______ Yes_____
When was your last Mammogram (if any)? __________________ Result ______________________
Do you have concerns about your breasts? _________________________________________
When was your last Bone Density (if any)? __________________ Result ______________________

***Past Medical / Surgical History(Include injuries and conditions requiring medication -i.e. -high blood pressure, seizures, diabetes, etc)***

| Condition/Disease | Date | Treatment |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ________________________________ Birthdate_________ Age _____ Date____________

| Have you had: | | | | |
|---|---|---|---|---|
| | Pain with intercourse? | No ___ | Yes___ | |
| | Bleeding with intercourse? | No ___ | Yes___ | |
| | Concerns about vaginal discharge? | No ___ | Yes___ | Explain ______________________________ |
| | Leaking of urine? | No ___ | Yes___ | Explain ______________________________ |
| | Pelvic infections? | No ___ | Yes___ | Explain ______________________________ |
| | Sexually transmitted diseases or HIV? | No ___ | Yes___ | Explain ______________________________ |

***Total number of pregnancies***

| Full Term | Premature | Cesarean Section | Vaginal Delivery | Ectopic | Miscarriage | Abortion | Stillborn | Live at Birth | Live at Present |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

***Pregnancy Details***

| Preg # | Sex | Month/ Year | Number of weeks | Weight | Hrs of Labor | Delivery Type | Obstetrical/Neonatal Problems | Delivery Doctor |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

***<u>Family History</u>***

Please complete if any of your close relatives have had any of the following:

| Disease | Circle Yes/No | Family Member | Family Members 1st Name | Age of Onset | Age of Death | Cause of Death (Circle) |
|---|---|---|---|---|---|---|
| Cancer of Breast | Yes No | | | | | Yes No |
| Cancer of Ovary | Yes No | | | | | Yes No |
| Cancer of Uterus | Yes No | | | | | Yes No |
| Cancer of Cervix | Yes No | | | | | Yes No |
| Cancer of Colon | Yes No | | | | | Yes No |
| Diabetes | Yes No | | | | | Yes No |
| Tuberculosis (TB) | Yes No | | | | | Yes No |
| Heart Disease | Yes No | | | | | Yes No |
| High Blood Pressure | Yes No | | | | | Yes No |
| Other: | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |



Revised 08/2015

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name ______________________________ Birthdate_________ Age _____ Date____________

***Social History***
Primary Language Spoken___________________________________ Race__________________________

Do you smoke? No_____ Yes_____ If yes, type of tobacco?_______________ Number of years_____ Pks/day_____

Do you drink alcohol? No_____ Yes_____ If yes, type of alcohol______________________________________________
How often?_________________________ Amount_____________________ Last drink_______________________

Do you consume caffeine? No_____ Yes_____ If yes, what kind?_______________ Amount_____________________

Do you use recreational drugs? No_____ Yes_____ If yes, what kind?_______________________________________

Exercise frequency? Daily_____ Never_____ Occasional_____ 2-3times/wk_____ 4 or more times/wk_____

How many sexual partners have you had? None_____ One_____ 2-5_____ 5+_____

Have you been exposed to sexual or physical violence or abuse? No_____ Yes_____

Are there animals in the home? No_____ Yes_____ If yes, what kind?_______________________________________
Is the patient the individual who cleans up after the animals? No_____ Yes_____

If medically necessary, would you agree to a transfusion? No_____ Yes_____

**REVIEW OF SYSTEMS**

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY, or write NONE.**

**Constitutional (Health in General):** Fatigue, fever, night sweats

**Ears, Nose, Mouth and Throat:** Eye discharge, vision loss, ear drainage, hearing loss, nasal drainage

**Respiratory:** Cough, wheezing, difficulty breathing or shortness of breath

**Cardiovascular:** Chest pain, irregular heartbeat, palpitations

**Gastrointestinal:** Abdominal pain, constipation, diarrhea, vomiting

**Genitourinary:** Painful periods, pain with urination, blood in urine, excessive menstrual bleeding, vaginal discharge

**Neurologic/Psychiatric:** Walking or balance difficulties, depression, anxiety, mood swings

**Dermatologic:** Skin itching, rash

**Musculoskeletal:** Bone weakness, joint weakness

**Hematology:** Easy bleeding, easy bruising

**Immunology:** Environmental allergies, food allergies