

NAME: _____ DATE: _____

OBSTETRICAL HISTORY PLEASE ENTER NUMBER OF PREGNANCIES: _____ FULL TERM _____ PRETERM _____
ABORTIONS OR MISCARRIAGE(S) _____ LIVE BIRTHS _____ # OF VAGINAL BIRTH (S) _____ # OF C-SECTION(S) _____
LIST ANY COMPLICATIONS: _____

PAST MEDICAL HISTORY: CHILDHOOD DISEASES - CHICKEN POX RHEUMATIC FEVER SCARLET FEVER
OTHER: _____

HAVE YOU HAD CHILDHOOD IMMUNIZATIONS? YES NO

LIST BELOW ANY HOSPITALIZATIONS/SURGERIES:

DATE	TYPE OF HOSPITALIZATION/SURGERY	REASON

ALLERGIES: YES NO PLEASE LIST: _____

MEDICATIONS: OVER-THE-COUNTER MEDICATIONS _____

PRESCRIPTIONS _____

SUPPLEMENTS _____

CALCIUM HOW MUCH PER DAY? _____ SPECIAL DIET? _____

HISTORY OF ANY BLOOD TRANSFUSIONS? HOW MANY? _____ **WHEN?** _____

TOBACCO - HOW MUCH PER DAY? _____ DRINK ALCOHOL? HOW MUCH? _____

RECREATIONAL DRUGS? IF SO, NAME THEM _____

EXERCISE - WHAT ACTIVITY AND HOW OFTEN? _____

DO YOU HAVE A HISTORY OF CANCER? BREAST COLON OVARIAN OTHER: _____

HEART DISEASE HYPERTENSION STROKES OTHER: _____

REVIEW OF SYSTEMS:

HEAD/EYES/EAR/NOSE AND THROAT: MIGRAINES HEADACHES VISUAL DISTURBANCES OTHER: _____

CARDIAC: MITRAL VALVE PROLAPSE HYPERTENSION HEART MURMUR CHEST PAIN

LUNGS: ASTHMA SHORTNESS OF BREATH CHEST CONGESTION

BREASTS: PERFORMS SELF BREAST EXAMS SELF BREAST EXAM TAUGHT AT LAST VISIT

ENDOCRINE: THYROID DIABETES OTHER: _____

GASTROINTESTINAL: DIARRHEA CONSTIPATION NAUSEA AND VOMITING IRRITABLE BOWEL SYNDROME
COLON POLYPS HEMORRHOIDS REFLUX

GENITOURINARY - URINARY INCONTINENCE PRIOR URINARY TRACT INFECTION

OTHER URINARY SYMPTOMS _____

ABNORMAL VAGINAL DISCHARGE VAGINAL ODOR VAGINAL ITCHING VAGINAL MASS/LUMP VAGINAL LESION

OTHER SIGNS/SYMPTOMS _____

FAMILY HISTORY: DO YOU HAVE ANY FAMILY HISTORY OF THE FOLLOWING? IF SO, PLEASE LIST WHO NEXT TO THE DISEASE/DISORDER (EXAMPLE: FATHER, MOTHER, SISTER, BROTHER, GRANDMOTHER, GRANDFATHER, UNCLE, AUNT, ETC.)

CANCER - BREAST COLON OVARIAN _____

DIABETES _____

HEART DISEASE _____

HYPERTENSION _____

STROKES _____

OSTEOPOROSIS _____

HIGH CHOLESTEROL _____

OTHER: _____

NO CHANGES SINCE LAST ANNUAL EXAM DATE: _____ / _____ (List month/year)

REVIEWED BY NURSE/MEDICAL ASSISTANT _____ DATE _____