North Florida OB GYN, LLC

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Patient's Name____ **DOB:** _____/_____/______ **Date:** ____________

Age:________ **Race** ________ **Referred by:** _____________________

Reason for this Appt_______________________ **Current birth control method** _____________________________

Primary Care Physician: _______________________________________

Last Mammogram: ______________**Last Bone Density:**______________ **Last Colonoscopy**:__________________

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, brother, sister or children)

Cancer	
Breast/Age	Yes No Who/age
Uterine	Yes No Who/age
Melanoma	Yes No Who/age
Ovarian	Yes No Who/age
Colon	Yes No Who/age
Other	

Allergies

Item	Reaction

Medication

Drug	Dose	How Often

Medication

Drug	Dose	How Often

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

☐ Heart Trouble ☐ Osteoporosis ☐ Breast Problems / Nipple Discharge ☐ Diabetes
☐ Kidney / Bladder Problems ☐ Anemia ☐ Hemorrhoids ☐ Anesthesia Problems
☐ High Blood Pressure ☐ Endometriosis ☐ Rectal Bleeding ☐ Antibiotics for Dental work
☐ Low Blood Pressure ☐ Fibroids ☐ Heart Murmur / MVP ☐ Cholesterol
☐ Thyroid Problems ☐ Pelvic Prolapse ☐ Anxiety ☐ Blood Disorders
☐ Depression ☐ Polycystic ovarian syndrome ☐ Seizures
☐ IBS ☐ Ulcer ☐ Stomach Trouble
☐ Cancer (type) ___________________________ ☐ 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

Surgical History:
(Including Hospitalizations)

Date	Procedure

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

Date	Delivery Type	Sex	Lbs/Oz	Complications

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