North Florida OB GYN, LLC

ST VINCENT IV
OB Only
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Patient's Name_____ **DOB:** ____/____/_____ **Date:** _____

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

Primary Care Physician: _____

Menstrual Hx: Last day of period _____ **Are your periods regular** ____ **How many days between periods** ___
Were you on birth control when you conceived _____

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 Disease**
- ❑ **Autoimmune disorder**
- ❑ **High Blood Pressure**
- ❑ **Kidney Disease**
- ❑ **Neurologic/epilepsy**
- ❑ **Depression/postpartum**
- ❑ **Hepatitis/liver disease**
- ❑ **Varicosities/phlebitis**
- ❑ **Thyroid dysfunction**
- ❑ **Trauma/Violence**
- ❑ **D (Rh) Sensitized**
- ❑ **Pulmonary (TB, Asthma)**
- ❑ **Seasonal Allergies**
- ❑ **Drug/Latex Allergy**
- ❑ **Breast Problems / Nipple Discharge**
- ❑ **Anesthetic Complications**
- ❑ **Uterine Anomalies**
- ❑ **Infertility**
- ❑ **Diabetes**
- ❑ **Stomach Trouble**
- ❑ **Cancer** (type)

❑ Other _____

STD type ❑**Chlamydia** ❑**Gonorrhea** ❑**Hepatitis** ❑**HIV** ❑**Genital Warts** ❑**Genital Herpes** ❑**Syphilis** ❑**HPV**

Have you ever had an abnormal pap? ____ yes ____ no Date: _____Treatment: _____

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/o	**Complications

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