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Obstetrics, Gynecology Infertility

PATIENT NAME: _____

BIRTH DATE: _____ AGE _____

ID NO.: _____

DATE: _____

PHYSICIAN HISTORY

☐ NEW PATIENT ☐ ESTABLISHED PATIENT	☐ CONSULTATION ☐ REPORT SENT: / /
PRIMARY CARE PHYSICIAN:	WHO SENT PATIENT:
OTHER PHYSICIAN(S):	
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):	CURRENT PRESCRIPTION MEDICATIONS: ☐ NONE
HISTORY OF PRESENT ILLNESS (HPI):	CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: ☐ NONE

CHANGES SINCE LAST VISIT	YES	NO	NOTES
ILLNESSES	☐	☐	
SURGERY	☐	☐	
NEW MEDICATIONS	☐	☐	
CHANGE IN FAMILY HISTORY	☐	☐	
NEW ALLERGIES	☐	☐	
CHANGE IN GYNECOLOGIC HISTORY	☐	☐	
CHANGE IN OBSTETRIC HISTORY	☐	☐	

ALLERGIES (DESCRIBE REACTION): ☐ NONE

LAST CERVICAL CANCER SCREENING: ☐ CYTOLOGY / / ☐ HPV TEST / /

LAST MAMMOGRAM: / /

LAST COLORECTAL SCREENING: / /

GYNECOLOGIC HISTORY (PH)

LMP: / / AGE AT MENARCHE: _____ LENGTH OF FLOW: _____ INTERVAL BETWEEN PERIODS: _____ RECENT CHANGES: _____

SEXUALLY ACTIVE ☐ YES ☐ NO EVER HAD SEX ☐ YES ☐ NO NUMBER OF PARTNERS (LIFETIME): _____

PARTNERS ARE: ☐ MEN ☐ WOMEN ☐ BOTH

CURRENT METHOD OF CONTRACEPTION: PAST CONTRACEPTIVE HISTORY:

OBSTETRIC HISTORY (PH)

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

PAST HISTORY (PH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

SURGERIES:

ILLNESSES (PHYSICAL AND MENTAL):

INJURIES:

IMMUNIZATIONS/TUBERCULOSIS TEST:

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PHYSICIAN HISTORY (Continued)

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

FAMILY HISTORY (FH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

MOTHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED–CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)

☐ DIABETES	☐ HEART DISEASE	☐ HYPERLIPIDEMIA
☐ CANCER	☐ HYPERTENSION	☐ DEEP VENOUS THROMBOEMBOLISM/PULMONARY EMBOLISM
☐ OSTEOPOROSIS	☐ OTHER ILLNESSES	

SOCIAL HISTORY (SH)

☐ NONCONTRIBUTORY ☐ NO INTERVAL CHANGE SINCE: / /

	YES	NO	NOTES
TOBACCO USE	☐	☐	
ALCOHOL USE–SPECIFY AMOUNT AND TYPE (12 OZ BEER = 5 OZ WINE = 1½ OZ LIQUOR)	☐	☐	
ILLEGAL/STREET DRUG USE	☐	☐	
MISUSE OF PRESCRIPTION DRUGS	☐	☐	
INTIMATE PARTNER VIOLENCE	☐	☐	
SEXUAL ABUSE	☐	☐	
HEALTH HAZARDS AT HOME/WORK	☐	☐	
SEAT BELT USE	☐	☐	

	YES	NO	NOTES
DIET DISCUSSED	☐	☐	
FOLIC ACID INTAKE	☐	☐	
CALCIUM INTAKE	☐	☐	
REGULAR EXERCISE	☐	☐	
CAFFEINE INTAKE	☐	☐	
ADVANCE DIRECTIVE (LIVING WILL)	☐	☐	
ORGAN DONATION	☐	☐	
OTHER			
☐ NO CHANGES SINCE: / /			

EMPLOYER/SCHOOL: _____

OCCUPATION/STUDENT: _____

FULL-TIME/PART-TIME (Please Circle) HOW LONG: _____

SPOUSE'S NAME: _____

EMPLOYER/SCHOOL: _____

OCCUPATION/STUDENT: _____

FULL-TIME/PART-TIME (Please Circle) HOW LONG: _____

WHOM MAY WE THANK FOR YOUR REFERRAL?: _____