

Dr. Susan M. Morrison

OB/GYN Patient Medical History Form



Name: _____ Date: _____

DOB: ____/____/____ Age: _____ Date of Last Physical: _____

What is the reason for your visit? _____

Medical History

Have you ever had any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pelvic Infections | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Blood Clots in Lungs/Legs | <input type="checkbox"/> Migraines | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Genetic Condition |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Drug or Alcohol Problem | <input type="checkbox"/> Cancer |

List all medication you are currently taking, including over-the-counter, birth control, vitamins & herbal remedies:

List any allergies: _____

Pharmacy to call in Prescription: _____ Phone#: _____

Obstetrical History

Check here if you have **never** been pregnant

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopic & abortions:

Year	M/F	Type of Delivery	Length of Pregnancy	Complications if any

Gynecologic History

Age of First Period _____ Age of Last Period _____ Cycle length is every _____ days & lasting _____ days. Date of last menstrual period _____

Periods are: Regular Irregular Painful not really bothersome

Flow is: Light Light to moderate Moderate to heavy Very heavy

Are you **sexually active**? Yes No Virginal

Method of **Birth Control**: Condoms Pills Patch Vaginal Ring Tubal Ligation IUD

Other:

none

❖ **Please continue on backside**

Have you ever had any of the following **STD's**? Chlamydia HPV HIV Gonorrhea Herpes
 Syphilis Trichomonas Hepatitis B Hepatitis C never had any

Have you ever had **any of the following**? Ovarian Cysts Fibrocystic Breasts Endometriosis Uterine Fibroids

Date of Last Pap smear: _____ Normal Abnormal

If abnormal have you ever had any of the following? Colposcopy LEEP Cryosurgery

Date of last mammogram: _____ Normal abnormal never had one

Date of last bone density: _____ Normal osteopenia osteoporosis never had one

Date of last colonoscopy: _____ Normal abnormal never had one

List any **Surgical** History with date(s): _____

Family History: List any close relatives with a history of the following indicating **Maternal** or **Paternal**

<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Ovarian Cancer		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Uterine Cancer		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Colon Cancer		<input type="checkbox"/> Other:	

Social History

Alcohol Use Yes No If yes, _____ drink(s) per day/week/month
 Tobacco Use Yes No If yes, _____ packs(s) per day for _____ years
 Street Drug Use Yes No Type and frequency _____
 Exercise Yes No Type and frequency _____
 Caffeine Yes No If yes, _____ caffeinated drinks per day/week

Review of Systems Do you currently have any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Generally Healthy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Recent Weight Gain or Loss | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Irregular vaginal bleeding |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Visions Problems (excluding glasses) | <input type="checkbox"/> Constipation | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Joint/muscle pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Urgency | <input type="checkbox"/> None of these |
| | <input type="checkbox"/> Bladder infection | |
| | <input type="checkbox"/> Stomach pains | |

To the best of my knowledge, the above information is complete & correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient Signature _____

Date: _____