

OB/GYN ASSOCIATES, P.A.
HEALTH HISTORY

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_\_

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Today's date \_\_\_\_\_ When was your last physical exam? \_\_\_\_\_ Last Period: \_\_\_\_\_

1. VITALS: Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_ lbs (Staff use: Temp: \_\_\_\_ RR: \_\_\_\_ Pulse: \_\_\_\_ )

2. PAST MEDICAL HISTORY - Have you ever had the following: \_\_\_\_\_ Patient denies any PMH

Table with 3 columns: Condition, Dates, Condition, Dates, Condition, Dates. Rows include: Last Pap Smear, Last Mammo, Last Colonoscopy, Last Bone Density Scan, Cancers, Type, Heart Disease, Uterine fibroids, Thyroid Disease, Diabetes, Abnormal Pap, Anxiety/Depression, Hepatitis, Gastric disorder, High Cholesterol, Anemia, Arthritis, Asthma, Hypertension, Bone Fractures, Headaches, Sickle Cell, Osteoporosis, Urinary Incontinence//UTI, Blood Transfusions, Endometriosis, Kidney Problem, Seizures, Infertility, Abnormal Mammogram, Trauma or Abuse, Sexually Transmitted Dis: Gonorrhea, Chlamydia, HPV, Genital Herpes, Syphilis

3. PAST SURGICAL HISTORY - Have you ever had the following \_\_\_\_\_ Patient denies any surgeries

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate year these occurred

Hysterectomy \_\_\_\_\_ C-Section \_\_\_\_\_ D&C \_\_\_\_\_ Abdominal \_\_\_\_\_
Appendix \_\_\_\_\_ Gallbladder \_\_\_\_\_ Breast Biopsy \_\_\_\_\_ Tonsils \_\_\_\_\_ Bladder \_\_\_\_\_
Cosmetic \_\_\_\_\_ Breast Implants Reduction \_\_\_\_\_
Tubal Ligation \_\_\_\_\_ Wisdom Teeth \_\_\_\_\_ Other \_\_\_\_\_

4. MEDICATIONS: Please list all medicines you are currently taking [ ] please continue on back of sheet

\_\_\_\_\_ Patient denies taking any Medications

Table with 3 columns: CURRENT MEDICATIONS:, DOSAGE (mg), how often per day?
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Please list all ALLERGIES (food, drugs, and environment) \_\_\_\_\_ Patient denies any Allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



--	--	--	--	--	--

8. Reason for today's visit-

---



---



---

**9. REVIEW OF SYSTEMS:**

**DO YOU HAVE NOW OR HAVE YOU HAD WANY OF THE BELOW PROBLEM WITHIN THE PAST YEAR:**

(Please circle anything for which you have a history of)

- Constitutional:** fever, stress, weight change, fatigue Insomnia
- Eyes:** change/ vision, blurred vision, double vision
- HENT:** sinus pain, headaches, sore throat, ear ache lightheadedness,  
head injury ear aches nose bleeding frequent colds
- Breast:** nipple discharge pain lumps/mass asymmetry redness
- Cardiovascular:** chest pain, irregular heartbeats, cold extremities Numbness, swelling  
shortness of breath with exertion
- Respiratory:** coughing shortness of breath, spitting up blood Asthma/wheezing
- Gastrointestinal:** diarrhea Loss of Appetite nausea/vomiting, change in bowel  
constipation, blood in stool
- Genitourinary:** urgency frequency painful urination night time frequency  
leakage of urine with coughing, sneezing or exertion
- Integument (Skin):** rash, itching new skin lesions Jaundice (yellowish)
- Neurological:** seizure tremors tingling or numbness, change in speech
- Musculoskeletal:** back pain, joint pain muscle pain swelling
- Endocrine:** frequent urination, excessive thirst cold/heat intolerance,
- Psychiatric:** anxiety, depression memory loss confusion

**Date:** \_\_\_\_\_ **Signature of Patient/ Parent if minor:** \_\_\_\_\_