Confidential Health History **Central Texas OB/GYN Associates**

Updated 06/25/12

Name:	Age:	Date of Birth:	Today's Date:
Primary Phone Number:	E-mail Address:		
Referring Physician / Person:	Primary Care Provider:		
Preferred Pharmacy Name:	Pharmacy Phone Number:		
Please describe any special problems or symptoms that you w ould like to discuss.			

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Blood Work		Bone Density	
Mammogram		Colonoscopy			
☐ Yes ☐ No History of abnormal pap?		☐ Yes ☐ No Would you accept blood products?			

PAST MEDICAL HISTORY Please check any medical problems that you have experienced.

☐ No Pertinent Medical History	☐ Cancer - Cervical	☐ Hypertension
☐ Abnormal Pap Smear	☐ Cancer - Colon	☐ Hyperthyroidism
☐ Acid Reflux - GERD	☐ Cancer - Ovarian	☐ Hypothyroidism
☐ Alcohol Dependence	☐ Cancer - Uterine	☐ Irregular Menses
☐ Alzheimer's Disease	☐ Dementia, Senile	☐ Irritable Bow el Syndrome
☐ Anemia	☐ Depression	☐ Jew ish Ancestry
☐ Anesthesia Complications	☐ Diabetes	☐ Kidney Disease
☐ Anxiety	☐ Drug Dependence	☐ Lung Disease (COPD)
☐ Arthritis	☐ Dysmenorrhea (Painful Periods)	☐ Migraine Headache
☐ Asthma	☐ Eating Disorder	☐ Osteopenia
☐ Autoimmune Disease (Lupus, MS, RA)	☐ Elevated Cholesterol	☐ Osteoporosis
☐ Blindness, legal	☐ Endometriosis	☐ Polycystic Ovarian Syndrome
☐ Blood Clots in Legs (DVT)	☐ Frequent Bladder / Kidney Infection	☐ Seizure Disorder
☐ Blood Clots in Lungs (Pulmonary Embolism)	☐ Gastric (Stomach) Ulcers	☐ Skin Disorders
☐ Blood Disorder	☐ Hearing Impaired	☐ Stroke
☐ Blood Transfusion	☐ Heart Disease	☐ Other:
☐ Cancer - Breast	☐ Hepatitis	☐ Other:

PAST SURGICAL HISTORY Please check all surgeries you have had.

☐ None	☐ Colonoscopy / Endoscopy	☐ Laparoscopy
☐ Adenoidectomy	☐ Cryosurgery (Freezing)	☐ LEEP - Loop Electrosurgical Excision Procedure
☐ Appendectomy	☐ Dental Surgery	☐ Lung Surgery
☐ Bariatric Surgery (Bypass, Lap-Band, Sleeve)	☐ Dilation and Curettage (D&C)	☐ Myomectomy (Removal of Fibroids)
☐ Bladder Surgery	☐ Endometrial Ablation	☐ Neck Surgery
☐ Bow el Resection	☐ Endometriosis (Removal/laser ablation/fulgaration)	☐ Nose Surgery
☐ Breast Surgery	☐ Exploratory Abdominal Surgery	☐ Oral Surgery
☐ Carpal Tunnel Surgery	☐ Eye Surgery	☐ Ovarian Cyst Removal
☐ Cerclage - Abdominal	☐ Heart Surgery	☐ Pelvic Reconstructive Surgery
☐ Cerclage - Cervical	☐ Hip Surgery	☐ Sling for Urinary Incontinence
☐ Cesarean Hysterectomy	☐ Hysterectomy	☐ Tubal Pregnancy (ectopic) Pregnancy
☐ Cesarean Section	☐ Hysteroscopy	☐ Tubal Pregnancy (ectopic) Removal
☐ Cholecystectomy (Removal of Gallbladder)	☐ Implantable Mesh	☐ Other:
☐ Cold Kinfe Cone	☐ Kidney Surgery	☐ Other:
☐ Colon Surgery	☐ Knee Surgery	☐ Other:

Name:	DOB:	Date:

CURRENT MEDICATION

List any **MEDICATIONS** you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

Do you take Calcium? ☐ Yes ☐ No If yes, amount:

Do you take Vitamin D? ☐ Yes ☐ No If yes, amount:

Do you take a Multiple vitamin or Prenatal Vitamin? ☐ Yes ☐ No

MEDICATION ALLERGIES

☐ NO KNOW DRUG ALLERGIES	☐ Iodine	☐ None
☐ Acetaminophen	☐ PENICILLINS	☐ Other:
☐ Codeine Sulfate	☐ Sulfa (Sulfonamides)	☐ Other:
☐ Erythromycin	☐ Tetracyclines	☐ Other:

FOOD ALLERGIES

☐ All Nuts	☐ Shell Fish (shrimp, crayfish, lobster, crab)	☐ Other:
☐ No Know n Food Allergies	☐ None	☐ Other:

ENVIRONMENTAL / LATEX ALLERGIES

☐ Adhesive tape	☐ Latex gloves	☐ None
☐ Bee Stings	☐ Seasonal	☐ Other:

FAMILY HISTORY Please check any medical conditions that apply to your blood related family and indicate w hich family member.

☐ Family History of Asthma	☐ Family History of High Cholesterol
☐ Family History of Autoimmune Disorders	☐ Family History of Hypertension
☐ Family History of Blood Clots (Lungs / Legs)	☐ Family History of Kidney Disorder
☐ Family History of Breast Cancer	☐ Family History of Lupus
☐ Family History of Cancer of Genital Organ	☐ Family History of Multiple Sclerosis (MS)
☐ Family History of Colon / GI Cancer	☐ Family History of Osteopenia / Osteoporosis
☐ Family History of DES Exposure	☐ Family History of Skin Conditions
☐ Family History of Diabetes	☐ Other:
☐ Family History of Heart Disease	☐ Other:

GENETIC

☐ Yes ☐ No Personal or Family Genetic Disorders	☐ Yes ☐ No Dow n's Syndrome (Trisomy 21)
☐ Yes ☐ No Advanced Maternal Age (> 35) 1st pregnancy	☐ Yes ☐ No Fragile X Syndrome or Mental Retardation
☐ Yes ☐ No Advanced Maternal Age (> 35) subsequent pregnancy	☐ Yes ☐ No Genetic or Chromosomal Disorder
☐ Yes ☐ No Ashkenazi Jew ish Decent	☐ Yes ☐ No Hemophilia or Other Blood Disorders
☐ Yes ☐ No Asian or Mediterranean Decent (Thalassemia)	☐ Yes ☐ No Huntington's Chorea
☐ Yes ☐ No BRCA 1 or 2 Mutation	☐ Yes ☐ No Maternal Metabolic Disorder (PKU, Diabetes)
☐ Yes ☐ No Canavan, Tay-Sachs, Noonan Disease	☐ Yes ☐ No Personal history of chicken pox or vaccine in the past
☐ Yes ☐ No Do you ow n cats	☐ Yes ☐ No None
☐ Yes ☐ No Do you change the litter	☐ Yes ☐ No Other
☐ Yes ☐ No Congenital Heart Defect	☐ Yes ☐ No Other

MENSTRUAL HISTORY

First day of last normal menstrual period - Date:	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Age period began:	Do you ever have spotting or bleeding in betw een your periods: ☐ Yes ☐ No
Number of days betw een periods:	
Length of periods (# of days of bleeding):	Is PMS a problem for you? ☐ Yes ☐ No
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Do you perform self breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every _____ hours

Method of birth control:

☐ Condoms	☐ Implanon	☐ Post Menopause
☐ Contraceptive Pills	☐ IUD	☐ Same Sex Partner
☐ Depo Provera	☐ Not Sexually Active	☐ Tubal Ligation
☐ Diaphragm	☐ Nuva Ring	☐ Vasectomy
☐ Essure	☐ Foam, Jelly, etc	☐ Other:
☐ Hysterectomy	☐ Patch	☐ None

Are you interested in a different method of birth control? ☐ Yes ☐ No

Name:	Date of Birth:	Today's Date:

REPRODUCTIVE PREGNANCY HISTORY

# of times pregnant:	# of term deliveries:	# of deliveries prior to 37 w eeks:	# of elective abortions:
# of miscarriages:	# of ectopic pregnancies:	# of multiple births:	# of living children:

PREGNANCY DETAILS # 1

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 2

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 3

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 4

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 5

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

PREGNANCY DETAILS # 6

Date:	Type of delivery:	Complications:
# w eeks at delivery:	☐ Vaginal	
Birth w eight:	☐ C-section	
Sex of child:	☐ Elective abortion	
Name:	☐ Miscarriage	

SOCIAL HISTORY

☐ Yes ☐ No Have you ever been physically abused in a relationship?

☐ Yes ☐ No Have you ever had an unw anted sexual encounter?

☐ Yes ☐ No Do you feel safe in your CURRENT relationship?

☐ Yes ☐ No Have you ever been emotionally / verbally abused by anyone important to you?

☐ Yes ☐ No Do you exercise? ☐ Frequently > 4x a w eek ☐ Daily ☐ Minimally - 1 - 2 x a w eek

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Engaged ☐ Partnered ☐ Single/Dating ☐ In a committed relationship ☐ Widow ed

Number of children living at home:

Husband / Partner's Occupation:

Patient Occupation:

Race: ☐ African American ☐ Caucasian ☐ Other: ☐ Asian ☐ Hispanic

Religious Preference:

Number of sexual partners in last 12 mos and lifetime.

12 Mos: Lifetime:

Sexual Preference: ☐ Heterosexual ☐ None ☐ Bi-sexual / Other ☐ Lesbian ☐ Other:

☐ Yes ☐ No Are you sexually active? ☐ Never ☐ Currently ☐ Previously

☐ Yes ☐ No Do you ever drink alcohol? ☐ Daily ☐ Socially

☐ Yes ☐ No Do you / did you ever use any recreational drugs or abuse prescription drugs?

☐ Yes ☐ No Do you / did you ever use tobacco?

If Yes, w hat type?	For how many years?	When did you stop?
☐ Chew ing Tobacco		Date:
☐ Smoking / Cigarettes	How much per day?	

Please check any Sexually Transmitted Disease you have had in the past.

☐ None ☐ Hepatitis C
☐ Chlamydia ☐ HIV or AIDS
☐ Cold Sores or Fever Blisters ☐ Human Papilloma Virus (HPV)
☐ Epstein Barr Virus (Mono) ☐ Molluscum Contagiosum
☐ Genital Herpes ☐ Pelvic Inflammatory Disease (PID)
☐ Genital Warts ☐ Syphilis
☐ Gonorrhea ☐ Trichomonas
☐ Hepatitis B ☐ Other:

Review Of Systems - Complete

Updated 10/24/11

Name:	Date Of Birth:	Date Of Service:

REVIEW OF SYSTEMS

Constitutional
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Weight Loss
- ☐ Yes ☐ No Weight Gain

Eyes
- ☐ Yes ☐ No Blurred Vision

ENT
- ☐ Yes ☐ No Headache
- ☐ Yes ☐ No Decreased Hearing
- ☐ Yes ☐ No Sore Throat
- ☐ Yes ☐ No Post Nasal Drip

Breasts
- ☐ Yes ☐ No Lumps
- ☐ Yes ☐ No Tenderness
- ☐ Yes ☐ No Swelling
- ☐ Yes ☐ No Nipple Discharge

Cardiovascular
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Irregular Heart Beats
- ☐ Yes ☐ No Syncope (Fainting)
- ☐ Yes ☐ No Lower Extremity Edema

Respiratory
- ☐ Yes ☐ No Shortness Of Breath
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Cough

GI
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation

GU
- ☐ Yes ☐ No Urgency
- ☐ Yes ☐ No Frequency
- ☐ Yes ☐ No Dysuria (Painful Urination)
- ☐ Yes ☐ No Incontinence

Skin
- ☐ Yes ☐ No Rash
- ☐ Yes ☐ No Change To Existing Skin Lesions or Moles

Neurologic
- ☐ Yes ☐ No Muscular Weakness
- ☐ Yes ☐ No Incoordination
- ☐ Yes ☐ No Tingling
- ☐ Yes ☐ No Numbness

Musculoskeletal
- ☐ Yes ☐ No Joint Pain
- ☐ Yes ☐ No Muscle Pain

Endocrine
- ☐ Yes ☐ No Polyuria (Excessive Urination)
- ☐ Yes ☐ No Polydipsia (Excessive Thirst)
- ☐ Yes ☐ No Cold Intolerance
- ☐ Yes ☐ No Heat Intolerance

Psychiatric
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Difficulty Sleeping
- ☐ Yes ☐ No Excessive Anger

Hematologic / Lymphatic
- ☐ Yes ☐ No Easy Bruising
- ☐ Yes ☐ No Easy Bleeding
- ☐ Yes ☐ No Lymph Node Enlargement

Allergic / Immunologic
- ☐ Yes ☐ No Sinus Allergy Symptoms
- ☐ Yes ☐ No Frequent Illness

Signature:	Date: