Greater Houston Ob/Gyn LLP
Patient Medical History Form

Name________________________ **DOB**______________ **Today's Date**____________

☐ Single ☐ Married ☐ Separated ☐ Widowed

Referred By:.____________________

Pharmacy Name:____________________

Pharmacy Tel.#____________________

Occupation:____________________

Would you accept blood transfusion? ____________________

Medical History Have you ever had any of the following?

- ☐ Anemia
- ☐ Heart Disease/Attack
- ☐ Gall Bladder Disease
- ☐ High Blood Pressure
- ☐ Liver Disease/Hepatitis
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Bleeding Problems
- ☐ Breast Cancer
- ☐ Birth Defects
- ☐ Ovarian Cancer
- ☐ Arthritis
- ☐ Blood Clots in Lungs/legs
- ☐ Pelvic Infections
- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Ovarian Cyst
- ☐ Chicken Pox
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Sickle Cell Disease
- ☐ Thyroid Problem
- ☐ Drug or Alcohol Problem
- ☐ Diabetes
- ☐ Genetic Condition
- ☐ Colon Cancer
- ☐ Other Cancer

List all medications & dose you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

List any allergies to medications____________________ ☐No Known Allergies

Reaction:.____________________

Surgical History

Date	Surgery

Obstetrical History

☐ Check here if you have never been pregnant

☐ Check here if you have adopted children

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal) and abortions:

Year	M/F	Infant's Weight	Type of Delivery	Gestational Age at delivery	Delivering Doctor	Problems

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Gyn History

Last Mestrual Period:______________________ Age of first period__________

Interval between cycles: every_____days Lasting? ☐ 1-3 days ☐ 4-6 days ☐ 7-9 days

Periods are: ☐ Regular ☐ Irregular ☐ Painful (Cramping/aching) ☐ Not really bothersome

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

☐ Menopause Age:__________ ☐ Hysterectomy Type/Date:__________________

Are you sexually active? ☐ Yes ☐ No ☐ Virginal

Recent New partners? ☐ Yes ☐ No

Number of lifetime partners__________

Sexual Preference: ☐ Male ☐ Female ☐ Both

Birth Control Method: ☐ condoms ☐ pills ☐ patch ☐ vaginal ring ☐ tubal/Essure ☐ natural family planning ☐ partner with vasectomy ☐ IUD type________ year inserted_______ ☐ Other ☐ None

Have you ever had any of the following STD's? ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Syphilis ☐ Trichomonas ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ None

Have you ever received Gardasil (HPV) Vaccine? ☐ Yes ☐ No

If Yes, Date:__________________ Received all three doses?__________________

Have you ever had any of the following? ☐ Fibrocystic breasts ☐ Ovarian Cysts ☐ Endometriosis ☐ Uterine Fibroids

Date of last pap smear__________ ☐ Normal ☐ Abnormal

Have you ever needed any of the following for an abnormal pap? ☐ Colposcopy ☐ Cryosurgery ☐ Leep/Laser/Conization ☐ None

Date of last mammogram__________ ☐ Normal ☐ Abnormal ☐ Never had one

Date of last bone density__________ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had one

Date of last colonoscopy__________ ☐ Never had one

Family History

Please list any close relatives with history of the following:

☐ Breast Cancer__________________

☐ Ovarian Cancer__________________

☐ Colon Cancer__________________

☐ Uterine Cancer__________________

☐ Genetic disorders__________________

☐ others__________________

Please list Relationship/Age at Diagnosis/Status

☐ High blood pressure__________________

☐ Diabetes__________________

☐ Heart Disease (heart attack, stroke, bypass surgery)__________________

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Social History

Alcohol use	☐ Yes	☐ No	If yes,________drink(s) per day/week/month
Tobacco use	☐ Yes	☐ No	If yes,________pack(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 drink (coffee, tea, soda) per day/week
Sexual Abuse	☐ Yes	☐ No	If yes, are you safe now? ☐ Yes ☐ No Counseling ☐ Yes ☐ No
Physical Abuse	☐ Yes	☐ No	If yes, are you safe now? ☐ Yes ☐ No Counseling ☐ Yes ☐ No
Emotional Abuse	☐ Yes	☐ No	If yes, are you safe now? ☐ Yes ☐ No Counseling ☐ Yes ☐ No

Patient Signature____ Date:_________________