

OB/GYN ASSOCIATES OF ALABAMA, P.C.

Patient's Name _____ DOB _____ Age _____ Today's Date.

Are you here for an Annual Exam or a Problem? (Please circle one)

If you are having a problem, please explain, including how severe it is and how long it has lasted:

GYNECOLOGICAL HISTORY

Date of your last Menstrual period _____ Date of your last pap smear _____ Have you ever had an abnormal pap smear?. If yes, when? _____

Number of days between your periods _____ Cramping is, mild, moderate, severe (circle one) Date of your last mammogram _____ Have you ever had an abnormal mammo?. If yes, when? _____

Are you sexually active? _____ Birth Control: now _____ past _____ (pill, IUD, etc)

How many days do you bleed? _____

OBSTETRIC HISTORY

		Number			Number			Number
Pregnancies			Abortions			Miscarriages		
Premature Births: (<37 weeks)			Live Births			Living Children		
No.	Birth Date	Weight at brth	Baby's Sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean, Etc.)	Compl cations?		
1.								
2.								
3.								
4.								
5.								

OPERATIONS / HOSPITALIZATIONS

Reason	Date	Hospital

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

PLEASE LIST ANY DRUG ALLERGIES:

PERSONAL PROFILE

Sexual Orientation n Heterosexual Q Homosexual D Bisexual Marital Status Q Married n Single D Living with Partner D Widowed Q Divorced School Completed Q High School Q College Q Graduate Degree Q Other _____ Current or most recent job _____ Do you smoke? _____ Packs per day _____

Alcohol n ^{Yes} D No Drinks per day _____ Drug use? _____ Drinks per week _____

Regular Exercise? _____ Other Pertinent Personal Info _____ How often? _____

PAST MEDICAL / FAMILY HISTORY

Mother: Living Deceased - Cause:

Age: Failier D Living Deceased - Cause: Age¹

In the following section please mark all illnesses that apply to you and / or your family members, now or in the past. If you mark an illness for a family member please indicate which relative and age of onset. (Some illnesses are not applicable for family members.)

Illness	You	Family	Relative(s) / age of onset	Illness	You	Family	Relative(s) / age of onset
Osteoporosis (weak bones)	n	n		Arthritis	n	NA	
Breast Cancer	n	a		Back Problems	n	NA	
Cervical Cancer	G	a		Lupus	n	n	
Colon Cancer	n	a		Seizures/Convulsions/Epilepsy	n	NA	
Ovarian Cancer	n	a		Stroke	n	n	
Uterine Cancer	n	a		Depression/Anxiety	n	NA	
Heart Attack	n	a		Eating Disorder	n	MA	
Heart Disease	n	a		Psychiatric Disorders	n	NA	
High Blood Pressure	a	a		Asthma	n	NA	
High Cholesterol	a	a		Lung Disease	n	n	
Bowel Problems	a	NA		Tuberculosis	n	NA	
Liver Disease	a	n		Kidney Stones	n	NA	
Reflux	a	MA		Hepatitis	n	NA	
Ulcers	a	NA		HIV/AIDS	n	NA	
Diabetes	n	a		Rheumatic Fever	n	NA	
Thyroid Disease	a	n		Sexually Trasmited Disease	n	NA	
Anemia	a	n		Genetic Abnormalities	n	n	
Blood Clots in Lungs or Legs	a	n		Other	n	D	
Blood Transfusion	n	NA					

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now

LEyes	6. Genitourinary Continued
n Double Vision	n Painful Intercourse
Q Spots before Eyes	n Fibroids
d Vision Changes	D Infertility
2. Ear, Nose, and Throat	D DES Exposure
Q Earaches	D Abnormal Vaginal Discharge
G Ringing in Ears	7. Musculoskeletal
G Sore Throat	D Muscle Weakness
G Mouth Sores	G Muscle or Joint Pain
3. Cardiovascular	8a. Skin
n Painful Breathing	Q Rash
Q Chest Pain or Pressure	G Sores
G Difficulty Breathing on Exertion	G Changes in Moles
Q Swelling of Legs	8b. Breasts
4. Respiratory	n Pain in Breast
n Wheezing	Q Nipple Discharge
n Shortness of Breath	D Lumps
n Chronic Cough	9. Neurologic
5. Gastrointestinal	D Dizziness
D Frequent Diarrhea	n Severe Memory Problems
Q Bloody Stool	d Frequent or Severe Headaches
D Nausea/Aomiting /In digestion	10. Psychiatric
Q Constipation	n Depression or Frequent Crying
O Involuntary loss of gas or stool	D Severe Anxiety
6. Genitourinary	11. Endocrine
Q Blood in Urine	O Hair Loss
Q Pain with Urination	n Heat/Cold Intolerance
G Strong Urgency to Urinate	D Abnormal Thirst
G Frequent urination	D Hot Flashes
G Incomplete emptying	12. Hematologic/Lymphatic
G Involuntary/Unintended Urine Loss	n Frequent Bruises
G Urine Loss when Coughing or Lifting	D Easy bleeding
Q Abnormal Bleeding	13. Constitutional
G Painful Periods	G Weight Loss
rj Premenstrual Syndrome (PMS)	G Weight Gain