

**BILTMORE OB-GYN
MEDICAL HISTORY**

| | | |
|--|----------------------|--|
| NAME: _____ | DATE: _____ | |
| REFERRING PHYSICIAN | | ALLERGIES TO MEDICATIONS |
| PLEASE INDICATE REASON FOR THIS OFFICE VISIT | | |
| | | CURRENT MEDICATIONS / HORMONES / VITAMINS / HERBS |
| MARRIED / PARTNERED/ DIVORCED / SEPARATED / SINGLE | | |
| OCCUPATION | | MEDICAL HISTORY |
| DO YOU LIVE ALONE? | | DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING? |
| GYNECOLOGICAL HISTORY | | BLOOD TRANSFUSIONS |
| AGE PERIODS BEGAN | | HEART DISEASE / MURMUR |
| LAST MENSTRUAL PERIOD | | HIGH BLOOD PRESSURE |
| # DAYS PERIOD LAST | | STROKE |
| # DAYS BETWEEN PERIODS | | EPILEPSY / SEIZURES |
| PRESENT METHOD OF BIRTH CONTROL | | MIGRAINES |
| LAST PAP SMEAR (DATE) _____ RESULT _____ | | DEPRESSION / PSYCHOLOGICAL ILLNESS |
| | | ASTHMA |
| DO YOU HAVE A HISTORY OF: (INCLUDE DATES) | | PULMONARY EMBOLISM |
| ABNORMAL PAP SMEAR | | OTHER LUNG DISEASE |
| COLPOSCOPY / CRYOSURGERY / LASER SURGERY | | PHLEBITIS / DVT |
| GENITAL WARTS / HERPES / CHLAMYDIA / GONORRHEA | | KIDNEY STONES OR OTHER DISEASE |
| NIGHT SWEATS / HOT FLASHES / VAGINAL DRYNESS | | THYROID DISEASE |
| (CIRCLE IF APPLIES) | | DIABETES |
| LEAKING OF URINE | | HEPATITIS / LIVER DISEASE |
| PELVIC INFLAMMATORY DISEASE | | GALLBLADDER DISEASE |
| INFERTILITY | | ANOREXIA / BULIMIA / EATING DISORDER |
| ENDOMETRIOSIS | | ANEMIA / BLOOD DISORDER |
| DES EXPOSURE | | CANCER |
| INFREQUENT OR IRREGULAR PERIODS | | COLLAGEN VASCULAR DISEASE / LUPUS |
| OVARIAN CYSTS | | ARTHRITIS |
| OVARIAN CANCER | | FIBROMYALGIA |
| UTERINE CANCER | | CHRONIC FATIGUE |
| FIBROIDS | | OSTEOPOROSIS |
| BREAST DISEASE | | URINARY PROBLEMS |
| BREAST SURGERY | | BOWEL PROBLEMS |
| BREAST D/C | | GLAUCOMA |
| DATE OF LAST MAMMOGRAM | | |
| MAMMOGRAM RESULT | | LAST CHOLESTEROL TEST (DATE / RESULT) |
| | | LAST FASTING BLOOD SUGAR (DATE / RESULT) |
| PREGNANCY HISTORY | | LAST SIGMOIDOSCOPY (DATE / RESULT) |
| NUMBER OF ELECTIVE ABORTIONS | | LAST BONE DENSITY (DATE / RESULT) |
| NUMBER OF MISCARRIAGES | | LAST IMMUNIZATION FOR TETANUS |
| NUMBER OF CHILDREN | | HAVE YOU BEEN IMMUNIZED FOR HEPATITIS B? YES ___ NO ___ |
| NUMBER OF VAGINAL DELIVERIES | | HAVE YOU BEEN IMMUNIZED FOR PNEUMOCOCCAL? YES ___ NO ___ |
| NUMBER OF C SECTIONS | | |
| COMPLICATIONS | | CAFFEINE (CUPS OF COFFEE, TEA, SODA / DAY) |
| | | CURRENT NUMBER CIGARETTES PER DAY |
| PAST SURGICAL HISTORY / HOSPITALIZATIONS | | PAST CIGARETTE USE (# OF YEARS) |
| YEAR(S), PROCEDURES(S) | | CURRENT AND PAST ALCOHOL INTAKE |
| | | STREET DRUG USE? YES ___ NO ___ |
| FAMILY HISTORY | | EXERCISE? YES ___ NO ___ |
| BREAST CANCER | STROKE | EXERCISE (FREQUENCY) |
| OVARIAN CANCER | HIGH CHOLESTEROL | EXERCISE (DURATION) |
| UTERINE CANCER | OSTEOPOROSIS | DO YOU PERFORM SELF BREAST EXAMS? (YES / NO) |
| COLON CANCER | BLOOD CLOTS | SUN EXPOSURE? |
| DIABETES | ALZHEIMERS | SPF # |
| HIGH BLOOD PRESSURE | THYROID DISEASE | |
| HEART ATTACK / HEART DISEASE | OTHER | |
| PATIENT NAME _____ | CHART # _____ | DOB _____ |