Contemporary OB/GYN Associates, LLC

Confidential Medical History

Patient Name: ______________________________ **Date:** __________

Race: __________ African American __________ Asian __________ Caucasian
__________ Hispanic Other ____________________

Past Medical History

Gynecological History: Please Mark All That Apply

__________ Abnormal Pap Smear
__________ Cervical Cancer
__________ Cervical Dysplasia
__________ Cervical Polyp
__________ Endometriosis
__________ Irregular Menses
__________ Hx of STD
__________ Menopausal Symptoms
__________ Performance of Monthly Self Breast Exams
__________ Uterine Prolapse
Vaginal Prolapse
Other ______________________________

Breast History: Please Mark All That Apply

__________ Abnormal Mammogram
__________ Breast Cancer
__________ Breast Cysts / Mass
Other: ______________________________

Cardiovascular History: Please Mark All That Apply

__________ Cardiac Arrest
__________ Hypertension
__________ Deep Venous Thrombosis
__________ Heart Murmur
__________ Mitral Valve Prolapse
__________ Phlebitis
__________ Transient Ischemic Attack
Other: ______________________________

Endocrinology History: Please Mark All That Apply

Crohn's Disease
__________ Diabetes
__________ High Cholesterol
__________ Hyperthyroidism
__________ Hypothyroidism
__________ Ovarian Dysfunction
__________ Vitamin Deficiency
Other: ______________________________

Hematologic History: Please Mark All That Apply

__________ Anemia
Other: ______________________________

Psychiatric History: Please Mark All That Apply

__________ Anxiety
__________ Depression
Other: ______________________________

Patient Signature: ____

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Surgical History: Please Indicate Any Surgical Procedure You Have Undergone As Well The Year

Procedure	Location	Year

Medications:

Medication	Prescribed By	Dose

Allergies: Please List All Medication Allergies

Medication	Symptoms / Reactions

Family Medical History: Please Mark All That Apply and Give Relation

		Breast Cancer			Glaucoma
		Cervical Cancer			Heart Disease
		Ovarian Cancer			Hypertension
		Uterine Cancer			Multiple Births
		DVT			Osteopenia
		Diabetes	Other		

Patient Signature: ____

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Menstrual History:

__________ Age of Onset
__________ Cycle Duration
__________ Cycle Interval
__________ Last Menstrual Period
__________ If Menopausal, year menses stopped

Obstetrical History:

Date	Hospital	Sex	Type of Delivery	Infant Weight	Months	Complications

Please Mark All That Apply

__________ Breech Delivery
__________ Cervical Incompetence
__________ Ectopic
__________ Gestational Diabetes
__________ Infertility
__________ Miscarriage
__________ Pre-Term Labor
__________ Post Partum Depression
__________ Termination
Other ______________________________
____
____

Social History: Please Mark All That Apply

__________ Alcohol Use
__________ Illicit Drug Use
__________ Increased Risk of Infection
__________ Multiple Sexual Partners
__________ New Sexual Partner
Other ______________________________
____

Exercise Regimen:

__________ Active: (4 or More Days Weekly)
__________ Moderate: (1 - 3 Days Weekly)
__________ Minimal: (1 Day a Week)
__________ Sedentary

Are you or have you ever been a victim of:

__________ Physical Abuse
__________ Emotional Abuse

Religion:

__________ Christian
__________ Jehovah Witness
__________ Jewish
__________ Hindu
__________ Muslim
Other __________________

Patient Signature: ____