## CONCORD OB/GYN MEDICAL HISTORY

DATE	PCP			
NAME	DATE OF BIRTH			
PHONE NUMBER	ALT PHONE			_
ALLERGIES (LE MEDICATIONS, FOOD, ENVIRONMENTAL)  Are you allergic to Latex? YES / NO				
What was the date of the FIRST day of your last menstrual	period?			
HISTORY Have you or a family member had the following? Please elaborate. GENETIC DISEASE HEART DISEASE HYPERTENSION	YOU		FAMILY MEMBER	
THYROID CONDITION KIDNEY DISEASE				
DIABETES HEPATITIS or LIVER DISEASE RESPIRATORY DISEASE				
NERVOUS, MENTAL, OR PSYCHIATRIC DISEASE				
BREAST CANCER UTERINE CANCER				
OVARIAN CANCER COLON CANCER				
STROKE OTHER MAJOR ILLNESSES/MEDICAL PROBLEMS				
SURGICAL HISTORY			1	
HAVE YOU HAD ANY SURGERY, IF SO WHAT KIND?			_	
HAVE YOU OR FAMILY MEMBERS HAD DIFFICULTIES WIT	H ANESTHESIA?			
SOCIAL HISTORY DO YOU SMOKE?			YES	NO
DO YOU DRINK 2 OR MORE ALCHOLIC BEVERAGES PER DAY?				
DO YOU CURRENTLY USE STREET DRUGS, OR HAVE A HISTORY OF IV DRUG USE? ARE YOU CURRENTLY MARRIED?				
HOW LONG HAVE YOU BEEN WITH YOUR PRESENT I	PARTNER?			
GYNECOLOGICAL HISTORY  HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?  WHEN DID YOU GET YOUR FIRST PERIOD (MENARCH	HEV9			
HOW MANY DAYS BETWEEN CYCLES?				
HOW MANY DAYS DO YOU FLOW? DESCRIBE FLOW (LIGHT/MEDIUM/HEAVY)				
DO YOU GET RECURRENT VAGINAL INFECTIONS? (YEAST, OTHER)				
EVER HAD A SEXUALLY TRANSMITTED DISEASE? (i.e. HAVE YOU EVER BEEN A VICTIM OF ABUSE? (SEXUAL, PH				
PRESENT METHOD OF CONTRACEPTION USED:	TSICAL, EMOTIONAL)			
PREVIOUS PREGNANCIES				
TYPE OF DELIVERY  NO. YEAR MISCARRIAGE VAGINAL C-SECTION	LABOR # OF HRS	BABY SEX	WEIGHT	
1				
3				
CURRENT MEDICATIONS				

9/20/2012