OBGYNASSOCIATES

OB-GYN Associates P.C.
45 East 85th Street, New York, NY 10028

CONFIDENTIAL PERSONAL HISTORY INFORMATION

Date _____

Name _____ Age _____ D.O.B. _____

Address _____ Telephone (H) _____

_____ Telephone (W) _____

Cellular _____

Are you? ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Reason for your visit _____

_____

What was the first day of your last menstrual period? _____

Are your periods? ( ) Regular ( ) Irregular

Days between menses _____ Duration of flow _____

Do you have? ( ) Heavy bleeding ( ) Bleeding between periods ( ) Painful periods

Age of first menstrual flow? _____

What is your method of birth control? _____

Do you experience pain or bleeding during or after intercourse? _____

Last pap smear date? _____ ( ) Normal ( ) Abnormal

Have you ever had an abnormal pap and what was done about it? _____

Last mammogram date? ( ) Normal ( ) Abnormal

Have you ever had an abnormal mammo, explain? _____

Total # of pregnancies _____ # of children _____ # of vaginal deliveries _____

# of miscarriages _____ #of c-section deliveries _____

# of elective abortions_____ # of ectopic pregnancies _____

Explain if you had complications during pregnancy: _____

_____

<u>This section is for obstetrical patient only</u>

For genetic testing purposes - mark your ethnic background:

( ) Jewish Ashkenazi ( ) Italian ( ) Asian
( ) Jewish Sephardic ( ) Black ( ) Other
( ) Hispanic/Latin ( ) White

Have you ever had? ( ) Chicken Pox ( ) Measles ( ) Rubella ( ) Rheumatic Fever

Do you have a history of? ( ) Incompetent Cervix ( ) Pre-term Labor
( ) Gestational Diabetes ( ) Pregnancy Induced Hypertension

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Do you smoke? _____ Quantity _____
Do you drink? _____ Quantity _____
Do you use illicit drugs? _____ Kind _____

Check below for medical problems:

( ) High blood pressure	( ) High cholesterol	( ) Endocrine disorder	( ) Asthma
( ) Heart murmur	( ) Liver disease	( ) Epilepsy	( ) Shortness of breath
( ) Heart disease	( ) Hepatitis	( ) Migraine headaches	( ) Tuberculosis
( ) Diverticular disease	( ) Urinary infections	( ) Depression	( ) Anemia
( ) Hemorrhoids	( ) Kidney disease	( ) Psychiatric problems	( ) Transfusions
( ) Inflammatory bowel	( ) Malignancy	( ) Diabetes	( ) Blood disorder
( ) Breast cancer	( ) Gynecological cancer	( ) Endometriosis	( ) Colon Cancer

( ) Other _____

Mark if you have had any of these sexually transmitted diseases:

( ) Gonorrhea	( ) Herpes	( ) Genital warts
( ) Chlamydia	( ) Syphilis	( ) HIV infection

( ) Other _____

List any medication that you may be **ALLERGIC** to:

_____ _____

_____ _____

List any medications you are taking (Include prescription, non-prescription, vitamins and over the counter):

_____

_____

List any surgical procedures you have had and the place and date you had it:

_____

_____

Family History

Mark any medical problems in your family:

( ) Heart	( ) High blood pressure	( ) Psychiatric	( ) Breast Cancer
( ) Kidney	( ) Genetic Abnormalities	( ) Alzheimerôs	( ) Gynecological cancer
( ) Diabetes	( ) Tuberculosis	( ) Osteoporosis	( ) Colon cancer

( ) Other _____

Mother: Alive Age _____ Medical Problems _____
Deceased Age _____ Cause of Death _____
Father: Alive Age _____ Medical Problems _____
Deceased Age _____ Cause of Death _____

Number of siblings alive _____ Medical Problems _____
Number of siblings deceased _____ Cause of death _____

Referred by: _____
If you have pertinent records, please give them to the receptionist.

Signature _____