ob·gyn SOUTH, P.C.

Before I formed you in the womb, I knew you.
Jeremiah 1:5

Medical Record #: _____

Initial Patient ROS, PFSH

Name: _____ Date: _____ Age: _____

❑ Single ❑ Married ❑ Widowed ❑ Divorced Religious Preference: _____

Date of last physical examination: _____ Referred by: _____

Problems you wish to discuss with the physician

_____

_____

How many pregnancies have you had? _____ Date of last menstrual period: _____

Resulting in (#): _____ Full 9 month ___Premature ___ Abortions (miscarriage) _____ # living children

Any complications during pregnancy, labor, delivery, or post partum period? _____

_____

Birth control method: ❑ Nothing ❑ Pill ❑ Vasectomy ❑ Hysterectomy ❑ Rhythm
❑ IUD ❑ Tubal Ligation ❑ Diaphragm ❑ Other: _____

Allergies: _____

Family	*Age*	*If living, Health*	*Age at Death*	*If deceased, cause*	*Has any blood relative ever had:*	*Please circle*	*Which Relative?*
Father					Breast Cancer	Yes No	
Mother					Diabetes	Yes No	
Brother/Sister					Tuberculosis	Yes No	
Brother/Sister					Cancer	Yes No	
Brother/Sister					High Blood Pres.	Yes No	
Brother/Sister					Heart Disease	Yes No	
Brother/Sister					Kidney Disease	Yes No	
Husband					Hepatitis	Yes No	
Son/Daughter					Alcoholism	Yes No	
Son/Daughter					Drug Addiction	Yes No	
Son/Daughter					Mental Disease	Yes No	
Son/Daughter					Venereal Disease	Yes No	
Son/Daughter					Peptic Ulcer	Yes No	
Son/Daughter					Osteoporosis	Yes No	

Personal History

Have you ever had:

German Measles _____ Epilepsy _____
Rheumatic Fever _____ Migraine Headaches _____
Heart Murmur _____ Tuberculosis _____
Gonorrhea _____ Diabetes _____
Syphilis _____ Cancer _____
Genital Herpes Virus _____ High Blood Pressure ____ Take Medicine ❑ Yes ❑ No
Anemia _____ Hemorrhoids _____
Gallbladder Disease _____ Sinus Trouble _____
Jaundice _____ Asthma _____
Hepatitis _____

Have you ever had:

Blood clot in legs _____ Kidney Disease _____
Bladder infection _____ Infection in womb and tubes _____

Have you ever been seriously injured? _____

How? _____ When? _____

What injuries did you sustain? _____

_____

Weight now _____ One year ago _____
Maximum weight _____ When? _____

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Have you ever had a blood transfusion? _____

Have you ever had anything wrong with your: Lungs _____

Heart _____

Kidneys _____

List all surgeries you have had

Type Date

_____

_____

_____

_____

List all illnesses which required hospitalization

Type Date

_____

_____

_____

_____

Do you now or have you had within the past year:	Yes	No
Uncontrollable loss of urine when coughing or sneezing?		
Uncontrollable loss of urine when bladder is full?		
Uncontrollable loss of urine just after emptying bladder?		
Uncontrollable loss of urine when you feel the urge to urinate?		
Uncontrollable loss of urine when sitting, standing, or lying quietly?		
Have you had sensation of stool bulging into birth canal when having movement?		
Have you ever had to express stool from rectum by placing fingers in vagina?		
Sensation of female organs dropping into birth canal?		
Are the above symptoms a problem to you?		
Pain on intercourse?		
Do you consider your sexual relationship satisfactory?		
Can you climax during intercourse?		
Date of last pelvic exam?		
Date of last PAP smear?		
Date of last breast exam?		
Date of last mammogram?		
Have you ever had an abnormal PAP smear?		
How old were you when your menses started?		

I am still having menstrual ❑ Yes ❑ No

Answer only if you are still having menstrual periods:	Yes	No
Do you have any pain with your periods?		
Does pain start the day flow starts?		
Pain starts how many days before flow starts?		
How many days between your periods?		
Are periods regular?		
How many days of menstrual flow?		
Periods: Heavy _____ Medium _____ Light _____		
Do you pass any clots in menstrual flow?		
Date of last menses?		

_____ _____

Patient Signature Date