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 ____________________
Rheumatic Fever ____________________
Heart Murmur ____________________
Gonorrhea ____________________
Syphilis ____________________
Genital Herpes Virus ____________________
Anemia ____________________
Gallbladder Disease ____________________
Jaundice ____________________
Hepatitis ____________________

Epilepsy ____________________
Migraine Headaches ____________________
Tuberculosis ____________________
Diabetes ____________________
Cancer ____________________
High Blood Pressure _____ Take Medicine ❑ Yes ❑ No
Hemorrhoids ____________________
Sinus Trouble ____________________
Asthma ____________________

Have you ever had:
Blood clot in legs ____________________
Bladder infection ____________________

Kidney Disease ____________________
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 ______________