

**DOWNRIVER OBSTETRICS & GYNECOLOGY
HISTORY FORM**

Please complete this medical history form & give it to the nurse when you are called in to the exam room.

Name _____ DOB _____ Today's Date _____

Allergies: (please write "none" if you have no allergies)

Allergy to: (medications, latex, environmental, etc)

Reaction (hives, rash, etc)

Family History: (List any illnesses your immediate family has: heart disease, cancer, bleeding disorders, stroke, etc.)

Illness

Relation to you

Gynecological History:

Abnormal Pap Infertility Fibroids Abnormal periods Pelvic Pain

Endometriosis STD's _____ Cancer Other _____

Date of Last Pap Smear _____

Date of Last Mammogram _____

OB History:

of Pregnancies _____ # of Miscarriages _____ # of Abortions _____ Currently pregnant? Y N

Delivery Date _____ Sex ____ Wt. _____ Vag/C-sec? _____ Complications _____

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Surgeries:

Type of surgery

Date

Type of surgery

Date

Medical History: (please check any that apply)

- | | |
|---|---|
| <input type="checkbox"/> Heart Disease/High Blood Pressure/Stroke | <input type="checkbox"/> Depression / Psychological |
| <input type="checkbox"/> Lung Disease (TB, Asthma, Pneumonia, CF) | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Problems / Ulcers / Reflux |
| <input type="checkbox"/> Jaundice / Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Speech / Hearing Problem |
| <input type="checkbox"/> Other: _____ | |

Social History:

How often do you drink? (Circle one) Socially Daily Never

Do you smoke? _____ If so, how many packs per day? _____

Do you or have you used any street drugs? _____ If so, which drugs? _____

Please include anything else you think we should know? _____

Current Medications, including Birth Control: (Please write "none" if you are not taking any medications)

Drug Name	Dosage	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunization History: (Check if you have received the following vaccines)

- Gardasil (HPV) Tdap (Tetanus/Diphtheria/Pertussis booster)

Primary Care Physician: _____ Referring Physician: _____

Name of Pharmacy	Location	Phone/Fax if known

Print Name: _____ Signature: _____ Date _____