Truesdale OB/GYN

Patient History Form

Today's Date _____

Patient's Name:_____**Birthdate**_____

Primary Care Physician:_____ **Date of Last Visit:**_____

☐ No Change **Allergies**

☐ **No** ☐ **Yes** **To what?**_____

Type of reaction: _____

☐ No Change **Medical History**

☐ **None**	☐ Heart Failure	☐ High Cholesterol	☐ Ulcer/GI Bleed	☐ Seizures
☐ Asthma	☐ Angina	☐ Diabetes	☐ Hepatitis	☐ Depression
☐ Pneumonia	☐ Stroke	☐ Thyroid Disease	☐ Bladder Infections	☐ Anxiety
☐ Heart Attack	☐ High Blood Pressure	☐ Osteoporosis	☐ Kidney Stone	☐ Cancer_____
☐ Blood Clots/Phlebitis	☐ Other_____			

☐ No Change **PRESENT MEDICATIONS**

(List any medications you are taking. INCLUDE Over the Counter Medications as well, such items as asprin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		

☐ No Change **Surgical History**

☐ **None**	☐ Mastectomy R L	☐ Ovarian Removal R L	☐ Blood Transfusions	
☐ Gallbladder	☐ Ectopic Pregnancy R L	☐ Ovarian Cystectomy R L	If yes, year _____	
☐ Appendectomy	☐ Hysterectomy	☐ Vaginal Repair		
☐ Tonsils	☐ D&C	☐ Bladder Repair	☐ History of Anesthesia	
☐ Breast Biopsy R L	☐ Tubal Ligation	☐ Cesarean Section	Reaction? ☐yes ☐no	
☐ Other _____		☐ Recent Surgery or Hospitalization_____		

☐ No Change **Family History (√ as Appropriate)**

	N	Y	Relative		N	Y	Relative
None	☐	☐	_____	High Blood Pressure	☐	☐	_____
Breast Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Ovarian Cancer	☐	☐	_____	Stroke	☐	☐	_____
Uterine Cancer	☐	☐	_____	High Cholesterol	☐	☐	_____
Colon Cancer	☐	☐	_____	Osteoporosis	☐	☐	_____
Other Cancer	☐	☐	_____	Thyroid Disease	☐	☐	_____

Please Continue On Back

GYN History

☐ Abnormal PAP Smear ☐ Sexually Transmitted Diseases ☐ Pelvic Infection ☐ Fibroids ☐ Abnormal Mammogram

Do you have:	No	Yes	If yes, explain:	
Problems with periods	☐	☐	_____	Date of Last Mammogram
Bleeding since menopause	☐	☐	_____	_____
Vaginal Itch/Discharge	☐	☐	_____	
Pain/bleeding with intercourse	☐	☐	_____	Date of Last Bone Density
Breast lump/pain/discharge	☐	☐	_____	_____
Problems with urination/leaking	☐	☐	_____	
Do you use contraception/birth control	☐	☐	_____	Date of Last Colonoscopy
Are you planning pregnancy	☐	☐	_____	_____

☐ No Change Obstetrical History

Age of First Period _____ Periods every ____days

Menstruate for_____days Flow: Heavy Med Light

Total pregnancies _____ Last Period Date _____

Live Births _____ Cesarean Sections _____

Miscarriages _____ Abortions _____

Stillbirths_____

Social History

Do you smoke? ☐ Yes ☐ No ☐ Quit #cigs/d_____ # years____

Do you drink? ☐ Yes ☐ No ☐ Quit # drinks/day _____

Do you use drugs? ☐ Yes ☐ No ☐ Quit Type: _____

Sexually active? ☐ Yes ☐ No # partners in last year_____

Regular Exercise ☐ Yes ☐ No Monthly breast exams ☐ Yes ☐ No

Sexual Orientation ☐ M ☐ F ☐ Both Safety belts ☐ Yes ☐ No

Regular Dental Visits ☐ Yes ☐ No Sun/tanning ☐ Yes ☐ No

Review of Systems (circle all that apply)

Fever	Tremors	Boils	Neck pain	Blood in the urine	Wheezing
Fatigue	Dizzy spells	Persistant itch	Back pain	Painful voiding	Frequent cough
Weight change	Excessive thirst	Chest pain	Abdominal pain	Frequent urination	Shortness of breath
Headache/Migraine	Too hot/Too cold	Varicose veins	Nausea/vomiting	Wake up to void	Ear infections
Blurred/Double Vision	Tired/Sluggish	Heart palpitations	Indigestion/heartburn	Considered suicide	Sore throat
Blood clotting problem	Severely depressed	Unsafe at home	Blood in the stool	Spitting up blood	Sinus problems
Numbness/Tingling	Skin rash	Joint pain			Swollen glands

Is there anything else you would like your provider to know?

_____

_____

_____

_____ _____

Physician's Signature Date