

**TO OUR PATIENTS:**

BECAUSE THE OB/GYN IS THE ONLY DOCTOR THAT MANY WOMEN SEE ON A REGULAR BASIS WE WOULD LIKE TO HELP IDENTIFY OTHER POTENTIAL HEALTH PROBLEMS THAT MAY NEED PROFESSIONAL CARE. PLEASE CHECK ANY OF THE FOLLOWING PROBLEMS THAT YOU HAVE AND INDICATE THE NAME OF ANY HEALTH CARE PERSON WHO IS CURRENTLY TREATING THAT PROBLEM.

**Past Medical & Family History PLEASE CHECK (-) IF YOU (PERSONAL) OR ANY BLOOD RELATIVE (FAMILY) HAD ANY OF THE FOLLOWING CONDITION.**

	Personal	Family		Personal	Family	Physician's Notes
Wt. Loss - Gain	_____	_____	Blood Transfusion	_____	_____	
Headaches/ Migraine	_____	_____	Anemia/ Blood Disorder	_____	_____	
Heart Dis (Valvular dis)(Rheumatic Dis)	_____	_____	Varicose Veins Phlebitis	_____	_____	
Hypertension	_____	_____	Skin Disease	_____	_____	
Respiratory Disease	_____	_____	Diabetes	_____	_____	
Breast Disease	_____	_____	Night Sweats	_____	_____	
Tuberculosis	_____	_____	Thyroid Disease	_____	_____	
Jaundice / Hepatitis	_____	_____	Cancer (Type)	_____	_____	
Gall Bladder Disease	_____	_____	Breast	_____	_____	
H. Hernia /Peptic Ulcer	_____	_____	Colon	_____	_____	
Bowel Disorders	_____	_____	Ovarian	_____	_____	
Kidney Disease	_____	_____	Epilepsy/ Neurological Disorders	_____	_____	
Urinary Incontinence	_____	_____	Arthritis	_____	_____	
Urinary Infections	_____	_____				

Previous Surgery (Example:

Hysterectomy). \_\_\_\_\_

Current Medication (list of dosage and frequency) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke? Y/N How much \_\_\_\_\_

Do you drink? Y/N How much \_\_\_\_\_

Do you wear your seat belt? Y/N \_\_\_\_\_

Do you use other recreational drugs? Y/N \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_