

NASH OB-GYN ASSOCIATES, P.A.  
Patient History - Revised 6/23/2003  
Patient Name \_\_\_\_\_

**Medical Doctor:** \_\_\_\_\_

**Allergies:**

Allergic to any medicine Yes No (please circle)  
Name of Medicine Reaction (rash, itching, shortness of breath, nausea, etc.)

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

**Immunizations:** Please provide year given.

Hepatitis B \_\_\_\_\_ Varicella (Chicken Pox) \_\_\_\_\_  
Flu shot \_\_\_\_\_ Tetanus (DT) \_\_\_\_\_  
Rubella (German Measles) \_\_\_\_\_

**Medications:** List any medications that you are presently taking.

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

**FAMILY Medical History:** Provide relationship i.e. Mother, Father, Sister, Brother, Grandparent

Cancer (indicate type) \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Stroke \_\_\_\_\_  
Heart Attack \_\_\_\_\_  
Depression \_\_\_\_\_  
Diabetes \_\_\_\_\_  
High Cholesterol \_\_\_\_\_  
Thyroid Disease \_\_\_\_\_  
Fibrocystic Breasts \_\_\_\_\_  
Stomach Ulcer \_\_\_\_\_  
Irritable Bowel \_\_\_\_\_  
Ulcerative Colitis \_\_\_\_\_  
Endometriosis \_\_\_\_\_  
Fibroids \_\_\_\_\_  
Severe Menstrual Cramps \_\_\_\_\_  
Osteopenia \_\_\_\_\_  
Osteoporosis \_\_\_\_\_  
Mother – Living or Deceased @ age \_\_\_\_ Father – Living or Deceased @ age \_\_\_\_

**Personal Surgical History:** Circle any surgical procedures that you have undergone:

Appendectomy Breast Biospy Left/Right D&C Breast Reduction  
Breast Augmentation C-Section \_\_\_\_\_ (indicate number) Sterilization  
Hysterectomy Vaginal/Abdominal Laparoscopy Tonsillectomy Gall Bladder  
Other \_\_\_\_\_

**PERSONAL Medical History:** (please circle)

Provide date of last: Bone Density \_\_\_\_\_, Mammogram \_\_\_\_\_, Pap Smear \_\_\_\_\_, Colonoscopy \_\_\_\_\_

Type of Birth Control used at present \_\_\_\_\_

- |  |   |
|--|---|
| Hypertension                                       | Cancer (indicate type) _____              |
| Mitral Valve Prolapse (antibiotics recommended)    | DVT                                       |
| Mitral Valve Prolapse (no antibiotics recommended) | Bipolar Disorder (Manic Depressive)       |
| Heart Attack                                       | Depression                                |
| Phlebitis  | Obsessive Compulsive Personality Disorder |
| Stroke   | Panic Attacks                             |
| Gestational Diabetes Mellitus                      | Postpartum Depression                     |
| Insulin Dependent Diabetes Mellitus                | Schizophrenia                             |
| Non-Insulin Dependent Diabetes Mellitus            | Sickle Cell Disease                       |
| Endometriosis                                      | Sickle Cell Trait                         |
| Fibroids   | Chlamydia                                 |
| Crohn's Disease                                    | Gonorrhea                                 |
| Gastric Ulcer                                      | Herpes                                    |
| GERD (Reflux)                                      | HIV                                       |
| Irritable Bowel Syndrome                           | HPV (genital warts)                       |
| Ulcerative Colitis                                 | Syphilis                                  |
| Hepatitis  | Bladder Infections                        |
| High Cholesterol                                   | Kidney Infections                         |
| Migraine Headaches                                 | Recurrent Urinary Tract Infection         |
| Osteopenia   | Urologic Surgery                          |
| Osteoporosis                                       | Bacterial Vaginosis                       |
| Abnormal Pap Smear (treatment) _____               | Yeast Infections                          |
| Anxiety  | Trichomonal Vaginitis                     |
| Varicella (Chicken Pox)                            | Hypothyroidism                            |
| Fibrocystic Breast Disease                         |   |

**Social History:**

Occupation \_\_\_\_\_

Exercise (circle) Inactive Light Moderate Heavy Vigorous

How much alcohol do you drink weekly \_\_\_\_\_

Tobacco Use Yes No Describe \_\_\_\_\_

Drug Use Yes No Describe \_\_\_\_\_

Religious Affiliation \_\_\_\_\_

**Pregnancy History:** How many times have you been pregnant \_\_\_\_\_

How many living children \_\_\_\_\_ Miscarriages \_\_\_\_\_ Ectopic Pregnancies \_\_\_\_\_

Any Complications \_\_\_\_\_

**Menstrual History:** Date of Last Period \_\_\_\_\_, # days of flow \_\_\_\_\_, flow is mild/moderate/heavy

Menstrual Cramps-non/mild/moderate/severe, Heaviest day of flow # of pads/tampons used \_\_\_\_\_

Pain interferes with Lifestyle Yes No Bleed between Periods Yes No

Cycle Length \_\_\_\_\_ (28-30 days, etc.) Age started menstrual cycle \_\_\_\_\_