Nash OB-GYN ASSOCIATES, P.A.

Patient History

Revised 10/10/23

Date: _____ Patient's Name: _____

Primary Care Provider's Name: _____

Primary Care Provider's Phone #: _____

ALLERGIES:

Are you allergic to any medication: ❑ Yes ❑ No

Name of medication	Reaction: *(rash, itching, shortness of breath, nausea, etc.)*
_____	_____
_____	_____
_____	_____

MEDICATIONS: *(List any medications you are presently taking, including vitamins/supplements)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL SURGICAL HISTORY: *(Check any surgical procedures you have undergone and list the date performed)*

- ❑ Appendectomy _____
- ❑ Breast Biopsy Left/Right _____
- ❑ Breast Reduction _____
- ❑ Breast Augmentation (implants) _____
- ❑ Colonoscopy _____
- ❑ C-Section ____ (indicate number) _____
- ❑ D & C _____
- ❑ Endometrial Ablation _____
- ❑ Gall Bladder _____
- ❑ Heart Surgery (type) _____
- ❑ Hysterectomy Vaginal/Abdominal _____
- ❑ LEEP/Conization _____
- ❑ Removal of Ovaries _____
- ❑ Sterilization _____
- ❑ Tonsillectomy _____
- ❑ Other _____
- ❑ Hysterectomy _____
  Reason for Hysterectomy _____

PERSONAL MEDICAL HISTORY: (check any medical problems that you currently have or have had in the past)

Cancer (indicate type)
- ❑ Breast
- ❑ Cervical
- ❑ Colon
- ❑ Endometrial
- ❑ Lung
- ❑ Ovarian
- ❑ Other _____

Cardiac (heart)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Attack
- ❑ Mitral Valve Prolapse

Endocrinology
- ❑ Diabetes Mellitus (during pregnancy)
- ❑ Diabetes Mellitus (non-insulin dependent)
- ❑ Diabetes (insulin dependent)
- ❑ Thyroid Problems
  - ❍ Hypothyroidism
  - ❍ Hyperthyroidism
- ❑ Osteoporosis
- ❑ Osteopenia

Gastrointestinal
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Gallbladder Disease
- ❑ GERD (Reflux)
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Liver Disease
- ❑ Hepatitis

Hematology
- ❑ Anemia
- ❑ Blood Clotting Disorder
- ❑ Blood Transfusion
- ❑ DVT (Deep Vein Thrombosis)
- ❑ PE (Pulmonary Embolism/ Clot in Lung)
- ❑ Sickle Cell Disease/Trait

Infectious Disease
- ❑ Chicken Pox
- ❑ Shingles
- ❑ HIV
- ❑ Tuberculosis/ Positive PPD

Neurology
- ❑ Alzheimer's/Dementia
- ❑ Headache/Migraines
- ❑ Numbness in Hands/Feet
- ❑ Seizures/Epilepsy
- ❑ Stroke

Psychiatric
- ❑ ADD/ADHD
- ❑ Anxiety
- ❑ Bipolar Disease
- ❑ Depression
- ❑ Eating Disorder
- ❑ Panic Attacks

Pulmonary
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Seasonal Allergies

Rheumatology
- ❑ Arthritis
- ❑ Autoimmune Disease
- ❑ Fibromyalgia

Urology
- ❑ Frequent Urinary Tract Infections
- ❑ Hematuria (blood in urine)
- ❑ Kidney Disease
- ❑ Kidney Infection
- ❑ Incontinence (bladder leakage)

CONTINUED ON REVERSE SIDE ➤

SOCIAL HISTORY:

Do you smoke cigarettes? ❑ Yes ❑ No How much per day: _____

Have you used tobacco products in the past? ❑ Yes ❑ No If yes, when did you stop smoking: _____

Do you use e-cigarettes or vape? ❑ Yes ❑ No Explain: _____

Does anyone else in your household smoke cigarettes? ❑ Yes ❑ No Explain: _____

Alcohol use: ❑ Yes ❑ No How much per day/week: _____

Drug use: ❑ Yes ❑ No Describe: _____

Caffeine: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Exercise: ❑ Light ❑ Moderate ❑ Heavy

Occupation: _____ Education Level Completed: _____

Relationship Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Religious Affiliation: _____

Is a blood transfusion acceptable in an emergency? ❑ Yes ❑ No

What is your gender identity? _____ What is your sexual orientation? _____

GYN HISTORY:

Date of most recent Pap Smear: _____

Date of most recent Mammogram: _____

Date of most recent Bone Density: _____

Location of most recent Pap Smear: _____

Location of most recent Mammogram: _____

Location of most recent Bone Density: _____

History of: *(Please check all items that apply)*

❑ Abnormal Pap Smear
Describe: _____
❑ HPV/Genital Warts
❑ Endometriosis
❑ Fibroids
❑ Ovarian Problems
❑ PCOS
❑ Infertility
❑ Bacterial Vaginosis
❑ Yeast Infections
❑ Chlamydia
❑ Gonorrhea
❑ Trichomonas
❑ Herpes Simplex
❑ Syphilis

Are you sexually active? ❑ Yes ❑ No Current birth control method: _____

MENSTRUAL HISTORY:

Age started menstrual cycle: _____ Date of last menstrual period: _____

# of days of bleeding with your period: _____ # of days from start of one period to the start of the next period: _____

Flow is: ❑ mild ❑ moderate ❑ heavy

Menstrual Cramps: ❑ None ❑ Mild ❑ Moderate ❑ Severe Bleed between Periods: ❑ Yes ❑ No

FAMILY MEDICAL HISTORY: *(Please indicate relationship: mother, father sister, brother, grandmother, etc.)*

❑ Cancer (breast/ovarian/uterine/colon/pancreas/other) _____

❑ Depression _____
❑ Diabetes _____
❑ Endometriosis _____
❑ Fibroids _____
❑ Heart Attack _____
❑ High Blood Pressure _____
❑ High Cholesterol _____
❑ Irritable Bowel _____
❑ Osteopenia _____
❑ Osteoporosis _____
❑ Stomach Ulcer _____
❑ Stroke _____
❑ Hypothyroidism _____
❑ Hyperthyroidism _____
❑ Ulcerative Colitis _____

IMMUNIZATIONS: *(Please provide the year the immunization was given)*

❑ Hepatitis B _____
❑ Flu shot _____
❑ COVID-19 Vaccine _____
❑ Varicella (Chicken Pox) _____
❑ Tetanus (DT) _____
❑ Gardasil/HPV _____

PREGNANCY HISTORY:

How many times have you been pregnant: _____ How many deliveries have you had: _____

# of living children: _____ # of miscarriages: _____ # of abortions: _____

# of Ectopic Pregnancies: _____