Meritas Health Obstetrics & Gynecology

Name:_____ DOB:_____ Age:_____ Primary Care Physician:_____

Medications: Give medication **name, dose & schedule.** Include vitamins, herbals, laxatives and over the counter medications.

_____
_____
_____

Patient Medical History

Do you have or have you ever had:

____Anemia	____Diabetes Type II	____History of Physical Abuse	___Migraine
____Anxiety	____Eating Disorder	____History of Sexual Abuse	___Mitral Valve Prolapse
____Arthritis	____Epilepsy/Seizure	____Hypertension	___Osteoporosis
____Bipolar Disease	____Esophageal Reflux	____Irritable Bowel Syndrome	___Peptic Ulcer
____Blood Clotting Disorder	____Fibromyalgia	____Kidney Disease	___Personality Disorder
____Cancer - type:_____	____Fracture	____Kidney Infection	___Phlebitis
____Cholesterol Elevated	____Gall Bladder Problems	____Liver Disease	___Postpartum Depression
____Colitis	____Heart Disease	____Lung Disease	___Thyroid Disorder
____Depression	____Heart Murmur	____Lupus	___Urinary Tract Infection
____Diabetes Gestational	____Hepatitis	____Marital/Partner Problems	___Other_____
____Diabetes Type I	____History of Emotional Abuse	____Mental Illness	

If you answered yes to any of the above please give detailed information/dates: _____

Allergies / Reactions: Please list all allergies and your reactions.

_____
_____
_____

Current Gynecological Review

Do you have:

____Bladder Problems	____Incontinence – Urine	_____Painful Periods	_____PMS/PMDD
____Incontinence – Feces	____Painful Intercourse	_____Pelvic Pain	

If you answered yes to any of the above please give detailed information/dates: _____

Past Patient Gynecological History

Have you ever had:

____Chlamydia	____HIV	____Pelvic Adhesions	
____Endometriosis	____HPV/Genital Warts	____PID	___Other_____
____Gonorrhea	____Infertility	____Personal Hx Breast Cancer	
____Herpes - HSV	____Pap HPV DNA test positive	____Uterine Fibroids	

If you answered yes to any of the above please give detailed information/dates: _____

Screening/Testing History:

When was your last Pap smear?_____
Have you ever had an abnormal Pap smear?_____ When_____Result_____Treatment_____
When was your last mammogram?_____ Result_____
Have you ever had an abnormal mammogram?___ When_____Result_____
Do you perform self breast exams?_____
When was your last Osteoporosis Screen?_____ Result_____
When was your last Colonoscopy?_____ Result_____
Have you had the Gardasil HPV Vaccine? Yes____ No____ 1st injection date_____2nd injection date_____3rd injection date_____

Patient Menstrual History:

Age period first started _____ Number of days between periods? _____
How many days do you flow? _____ Is flow: Light_____Medium_____Heavy_____
Use Tampons_____Pads_____Both_____
First Day of Last Period_____ Breakthrough Bleeding: Yes____No___ Clots: Yes____No_____

What birth control are you currently using?

_____Condoms	_____Birth Control Pills	____Vasectomy	
_____Depo Provera	_____Over the Counter(foam)	____Withdrawal	
_____Diaphragm	_____Rhythm Method	_____ Nexplanon	____None
_____IUD	_____Tubal Ligation	_____ Other:_____	

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Pregnancy History:

# of Pregnancies	Full Term Deliveries	Preterm Deliveries	Induced AB	Miscarriages	Ectopic	Multiples	Living

Past Pregnancy Details:

Date Mm/dd/yy	Weeks along	Hours in labor	Birth Wt.	Sex M/F	Type of Delivery (C-sect, Vaginal, VBAC, Forceps, Vacuum)	Anesthesia (Epidural, General Spinal, IV, None)	Early Labor?	Complications	Hospital

Patient Surgical History

Year	Surgery	Reason	Doctor	Hospital

Have you had breast augmentation?_____When:_____
Have you been told to take antibiotics with any dental or surgical procedure? Yes_____ No_____
Have you had anesthetic problems with surgery in the past? Yes_____ No_____
Will you accept a blood transfusion in the event of an emergency? Yes_____ No_____

Family History: Have any of your family members had the following (please specify mother, father, brother, sister, aunt, uncle, paternal grandmother or grandfather, maternal grandmother or grandfather, or other next to history):

_____ Anemia
_____ Anesthetic Problems in Surgery
_____ Bleeding Disorders
_____ Breast Cancer
_____Cardiac Disease
_____Cervical Cancer
_____Colon Cancer
_____Diabetes
_____Elevated Cholesterol
_____High Blood Pressure
_____Kidney Disease
_____Mental Illness
_____Osteoporosis
_____Ovarian Cancer
_____Tuberculosis
_____Uterine Cancer
_____Other:_____
_____No Known Family Medical History

Social History:

Have you ever had sex? _____
Are you currently sexually active? _____
More than 5 lifetime sexual partners? _____
Age you became sexually active? _____
New partner in the last 6 months? _____
Sexual Partners Female_____ Male_____Both_____

Please circle: Single Married Separated Divorced Widowed

Do you use alcohol? Never____Current_____Former_____ Type_____ How much_____Age Start____Age Stop____
Do you use tobacco? Never____Current_____Former_____ How much_____Age Start_____ Age stop_____
Do you use recreational drugs? Never___Current____Former____ Type_____ How much _____ Age Start___ Age Stop___

Employer_____ Job Description/Occupation_____

Religious Preference_____

I have answered these questions to the best of my knowledge.

Patient Signature:_____ Date:_____