Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY –OB/GYN

Patient Name: _____ Date of Birth: _____Age: ___

Address: _____

_____

Phone: _____ (☐ Home ☐ Cell ☐ Work) E-Mail: _____

Primary Insurance Company: _____ Policy #:_____

Primary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Secondary Insurance Company: _____ Policy #:_____

Secondary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

☐ Abnormal Discharge	☐ New OB	☐ Pre-Op Consult
☐ Abnormal Pap (Cervical Dysplasia)	☐ Painful/Heavy Periods	☐ Routine Prenatal Visit
☐ Birth Control Discussion	☐ Painful Sex	☐ Testing for Sex. Transmitted Infection
☐ Breast problem	☐ Pap Smear	☐ Urinary Problem
☐ Fibroids	☐ Pelvic Pain	☐ Vaginal Irritation/Problem
☐ Irregular Menstrual Bleeding	☐ Postmenopausal Bleeding	☐ Well Woman (Annual Check-up)
☐ IUD Check	☐ Postpartum Check-up	☐ Other:
☐ IUD Insertion	☐ Post-Op Check	☐ Other:
☐ IUD Removal	☐ Pre-conceptual Consult	☐ Other:

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Appendectomy		☐ Laparoscopic/Robotic Hysterectomy	
☐ Breast Biopsy		☐ Removal of fibroids (Myomectomy)	
☐ Breast Surgery		☐ Removal of ovary (Oophorectomy)	
☐ C-Section (s)		☐ Orthopedic Surgery	
☐ Dilation and Curettage (D&C)		☐ Removal of ovarian cyst (Cystectomy)	
☐ Ectopic Pregnancy Surgery		☐ Total Abdominal Hysterectomy	
☐ Endometrial Ablation		☐ Tubal Ligation (Tubes Tied)	
☐ Gallbladder Removal (Cholecystectomy)		☐ Other:	
☐ Hysteroscopy		☐ Other:	
☐ Laparoscopy-Reason:_____		☐ Other:	
☐ Laparotomy		☐ None	

Patient Name: _____ Date of Birth: _____

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)	**Dosage** (mg/ml)	**Frequency**
Name of Medication/Herb/Vitamin		
☐ None		

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Other:	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	
☐ Latex		☐ Other:	
☐ None			

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Anemia	☐ GI Problems	☐ Osteopenia
☐ Anesthesia Complications	☐ Heart Conditions	☐ Osteoporosis
☐ Asthma	☐ Hepatitis	☐ Psychiatric Problems/Illness
☐ Birth Defects or Inherited Disease	☐ High Blood Pressure	☐ Thyroid Problems
☐ Blood Clotting Disorder	☐ High Cholesterol	☐ Varicosities
☐ Breast Cancer	☐ Infertility	☐ Other:
☐ Cancer- Type:_____	☐ Kidney or Bladder Problems	☐ Other:
☐ Diabetes	☐ Lung Disease	☐ Other:
☐ Endometriosis	☐ Migraines	☐ None

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Occupation: _____

Education: ☐ less than High School ☐ Some H.S. ☐ H.S. graduate or equivalent ☐ 2 Year College ☐ 4 Year College ☐ Post Graduate Degree

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Live alone or with others? ☐ Alone ☐ With Others Number of Children: _____

Are you currently employed? ☐ Yes ☐ No

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Current Status Unknown

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Alcohol – Years of Use: _____

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit Drugs: _____ Illicit Drugs – Years of Use: _____

Advance Directive? ☐ Yes ☐ No Frequent air travel? ☐ Yes ☐ No

Live with cats/exposure to cat litter? ☐ Yes ☐ No

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Blood Clotting Disorders			
☐ Cancer, Breast			
☐ Cancer, Colon			
☐ Cancer, Endometrial			
☐ Cancer, Gastric			
☐ Cancer, Lung			
☐ Cancer, Ovarian			
☐ Cancer, Uterine			
☐ Diabetes			
☐ Heart Disease			
☐ High Blood Pressure			
☐ High Cholesterol			
☐ Neurologic Problems			
☐ Psychiatric Problems			
☐ Thyroid Problems			
☐ Other:			
☐ Other:			
☐ Other:			

☐ Other:			

Patient Name: _____ Date of Birth: _____

GYN HISTORY

Age at First Period _____

Age of Menopause _____

Frequency of Cycle (days) _____

Duration of Flow (days) _____

Flow _____Heavy _____ Moderate _____ Light

Painful Periods: ☐ Yes ☐ No

Date of Last Menstrual Period : _____ Date of Last Pap Smear : _____

Abnormal Pap: ☐ Yes ☐ No History of: ☐ Yes ☐ No When: _____

Date of Most Recent Mammogram _____

Date of Most Recent Bone Density: _____

Date of Last Colonoscopy : _____

Sexually Active? ☐ Yes ☐ No

Current Birth Control Method, if applicable: _____

HPV Vaccine: ☐ Yes ☐ No

History of Fibroids: ☐ Yes ☐ No

History of Sexually Transmitted Infections (STI)? ☐ Yes ☐ No

History of Herpes: ☐ Yes ☐ No

History of HPV: ☐ Yes ☐ No

OBSTETRIC HISTORY (Please check those items that apply)

# of Pregnancies _____	# Vaginal Deliveries _____	Full Term: ☐ Yes ☐ No
# of Miscarriages _____	# C-Sections _____	Pre-Term: ☐ Yes ☐ No
# of Abortions _____	# of Living Children _____	
# of Ectopics _____	Twins? _____	

GENETIC SCREENING & INFECTION HISTORY

☐ Patient's age will be 35 Years or older at Estimated Date of Delivery

☐ Thalassemia (Italian, Greek, Mediterranean, Or Asian Background): MCV < 80

☐ Neural Tube Defect (Spina Bifida)

☐ Congenital Heart Defect

☐ Down Syndrome

☐ Tay-Sachs (eg, Jewish, Cajun, French-Canadian)

Patient Name: _____

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GENETIC SCREENING & INFECTION HISTORY continued

- ☐ Canavan Disease
- ☐ Sickle Cell Disease or Trait (African-American)
- ☐ Hemophilia or other Blood Disorders
- ☐ Muscular Dystrophy
- ☐ Cystic Fibrosis
- ☐ Huntington's Chorea
- ☐ Mental Retardation/Autism

Other Inherited Genetic Or Chromosomal Disorder

- ☐ Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU)
- ☐ Patient or Baby's Father Had A Child With Birth Defects Not Listed Above
- ☐ Recurrent Pregnancy Loss, Or A Stillbirth
- ☐ Medications (including Supplements, Vitamins, Herbs, OTC Drugs), Illicit/Recreational Drugs, Alcohol

If Yes, List Agent(s) and Strength/Dosage: _____

Any Other Genetic History:

- ☐ Live with someone with TB or Exposed to TB
- ☐ Patient or partner has history of Genital Herpes
- ☐ Rash or viral illness since last Menstrual Period
- ☐ History of STD, Gonorrhea, Chlamydia, HPV, Syphilis
- ☐ Other Infection History? _____

PREVIOUS PREGNANCY PROBLEMS (Please check those items that apply)

☐ Advanced Maternal Age	☐ Premature Rupture of Membranes	☐ Velamentous cord insertion or 2 Vessel Cord
☐ Anemia	☐ Pre-term Labor	
☐ First Trimester Bleeding	☐ Previous C-Section	☐ Other:
☐ Gestational Diabetes	☐ RH Negative Status	☐ Other:
☐ Hyperemesis	☐ Twin Pregnancy	☐ Other:
☐ Placenta Previa		☐ Other: