

Desert West Obstetrics and Gynecology, Ltd.
Confidential Medical History

Name _____ Birthdate _____ Age _____ Date _____

| Allergies to medications/food/environment | Reaction |
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| Current Medications (Prescription, over the counter, herbal) | Prescribing Doctor | Dose | Instructions | Reason Used |
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What do you do so you don't become pregnant?

Diaphragm Condoms Sponge Rhythm IUD
 Withdrawal Depo Provera Vasectomy Norplant Pills
 Essure Tubal Ligation Implanon Ortho Evra Nuva Ring
 Other _____

First day of last period _____

What age were you when you started your first period? _____

Are your periods regular? _____

Is there bleeding between periods? _____

How often do your cycles occur? _____

For how many days do you bleed? _____

Flow is: scant mild mod severe incapacitating

Other symptoms with periods? _____

Date of last pap smear _____

Have you had an abnormal pap smear? No _____ Yes _____

Has this been treated? No _____ Yes _____

How? _____

Do you examine your breasts regularly? No _____ Yes _____

When was your last Mammogram (if any)? _____ Result _____

Do you have concerns about your breasts? _____

When was your last Bone Density (if any)? _____ Result _____

Past Medical / Surgical History (Include injuries and conditions requiring medication -i.e. -high blood pressure, seizures, diabetes, etc)

| Condition/Disease | Date | Treatment |
|-------------------|------|-----------|
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Name _____ Birthdate _____ Age _____ Date _____

Have you had: Pain with intercourse? No ___ Yes ___
 Bleeding with intercourse? No ___ Yes ___
 Concerns about vaginal discharge? No ___ Yes ___ Explain _____
 Leaking of urine? No ___ Yes ___ Explain _____
 Pelvic infections? No ___ Yes ___ Explain _____
 Sexually transmitted diseases? No ___ Yes ___ Explain _____

Total number of pregnancies

| Full Term | Premature | Cesarean Section | Vaginal Delivery | Ectopic | Miscarriage | Abortion | Stillborn | Live at Birth | Live at Present |
|-----------|-----------|------------------|------------------|---------|-------------|----------|-----------|---------------|-----------------|
| | | | | | | | | | |

Pregnancy Details

| Preg # | Sex | Month/Year | Number of weeks | Weight | Hrs of Labor | Delivery Type | Obstetrical/Neonatal Problems | Delivery Doctor |
|--------|-----|------------|-----------------|--------|--------------|---------------|-------------------------------|-----------------|
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Family History

Please complete if any of your close relatives have had any of the following:

| Disease | Circle Yes/No | Family Member | Family Members 1st Name | Age of Onset | Age of Death | Cause of Death (Circle) |
|---------------------|---------------|---------------|-------------------------|--------------|--------------|-------------------------|
| Cancer of Breast | Yes No | | | | | Yes No |
| Cancer of Ovary | Yes No | | | | | Yes No |
| Cancer of Uterus | Yes No | | | | | Yes No |
| Cancer of Cervix | Yes No | | | | | Yes No |
| Cancer of Colon | Yes No | | | | | Yes No |
| Diabetes | Yes No | | | | | Yes No |
| Tuberculosis (TB) | Yes No | | | | | Yes No |
| Heart Disease | Yes No | | | | | Yes No |
| High Blood Pressure | Yes No | | | | | Yes No |
| Other: | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |
| | | | | | | Yes No |

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Name _____ Birthdate _____ Age _____ Date _____

Social History

Primary Language Spoken _____ Race _____

Do you smoke? No _____ Yes _____ If yes, type of tobacco? _____ Number of years _____ Pks/day _____

Do you drink alcohol? No _____ Yes _____ If yes, type of alcohol _____
How often? _____ Amount _____ Last drink _____

Do you consume caffeine? No _____ Yes _____ If yes, what kind? _____ Amount _____

Do you use recreational drugs? No _____ Yes _____ If yes, what kind? _____

Exercise frequency? Daily _____ Never _____ Occasional _____ 2-3times/wk _____ 4 or more times/wk _____

How many sexual partners do you have? None _____ One _____ 2-5 _____ 5+ _____

Have you been exposed to sexual or physical violence or abuse? No _____ Yes _____

Are there animals in the home? No _____ Yes _____ If yes, what kind? _____

Is the patient the individual who cleans up after the animals? No _____ Yes _____

If medically necessary, would you agree to a transfusion? No _____ Yes _____

REVIEW OF SYSTEMS

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY, or write NONE.**

Constitutional (Health in General): Fatigue, fever, night sweats

Ears, Nose, Mouth and Throat: Eye discharge, vision loss, ear drainage, hearing loss, nasal drainage

Respiratory: Cough, wheezing, difficulty breathing or shortness of breath

Cardiovascular: Chest pain, irregular heartbeat, palpitations

Gastrointestinal: Abdominal pain, constipation, diarrhea, vomiting

Genitourinary: Painful periods, pain with urination, blood in urine, excessive menstrual bleeding, vaginal discharge

Neurologic/Psychiatric: Walking or balance difficulties, depression, anxiety, mood swings

Dermatologic: Skin itching, rash

Musculoskeletal: Bone weakness, joint weakness

Hematology: Easy bleeding, easy bruising

Immunology: Environmental allergies, food allergies