Dr. Susan M. Morrison

OB/GYN Patient Medical History Form

Name: _____ **Date:** _____

DOB: ____/____/____ **Age:** _____ **Date of Last Physical:** _____

What is the reason for your visit? _____

Medical History

- ☐ Anemia
- ☐ Heart Disease/Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Bleeding Problems
- ☐ Blood Clots in Lungs/Legs
- ☐ Gall Bladder Disease
- ☐ Liver Disease/Hepatitis

Have you ever had any of the following?

- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Pelvic Infections
- ☐ Arthritis
- ☐ Chicken Pox
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Drug or Alcohol Problem
- ☐ Diabetes
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sickle Cell Disease
- ☐ Thyroid Problem
- ☐ Blood Transfusion
- ☐ Genetic Condition
- ☐ Cancer

List all medication you are currently taking, including over-the-counter, birth control, vitamins & herbal remedies:

_____

_____

List any allergies: _____

Pharmacy to call in Prescription: _____ **Phone#:** _____

Obstetrical History

☐ Check here if you have **never** been pregnant

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopic & abortions:

Year	M/F	Type of Delivery	Length of Pregnancy	Complications if any

Gynecologic History

Age of First Period _____ Age of Last Period (if applicable) _____

Cycle length is every _____ Days lasting _____ days

Date of last menstrual period _____

Periods are: ☐ Regular ☐ Irregular ☐ Painful ☐ not really bothersome

Flow is: ☐ Light ☐ Light to moderate ☐ Moderate to heavy ☐ Very heavy

Are you **sexually active**? ☐ Yes ☐ No ☐ Virginal ☐ Same Sex Relationship

Method of **Birth Control**: ☐ Condoms ☐ Pills ☐ Patch ☐ Vaginal Ring ☐ Tubal Ligation ☐ IUD

☐ None/Other:

❖**Please continue on backside**

Have you ever had any of the following **STD's**? ☐ Chlamydia ☐ HPV ☐ HIV ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ Trichomonas ☐ Hepatitis B ☐ Hepatitis C ☐ never had any

Have you ever had **any of the following**? ☐ Ovarian Cysts ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Uterine Fibroids

Date of Last Pap smear:_____ ☐ Normal ☐ Abnormal

If abnormal have you ever had any of the following? ☐ Colposcopy ☐ LEEP ☐ Cryosurgery

Date of last mammogram:_____ ☐ Normal ☐ abnormal ☐ not applicable

Date of last bone density:_____ ☐ Normal ☐ osteopenia ☐ osteoporosis ☐ not applicable

Date of last colonoscopy:_____ ☐ Normal ☐ abnormal ☐ not applicable

List any Surgical History with date(s): _____

_____

_____

Family History: List any close relatives with a history of the following indicating **Maternal** or **Paternal**

☐ Breast Cancer		☐ High Blood Pressure	
☐ Ovarian Cancer		☐ Diabetes	
☐ Uterine Cancer		☐ Heart Disease	
☐ Colon Cancer		☐ Other:	

Social History

Alcohol Use	☐ Yes	☐ No	If yes,_____drink(s) per day/week/month
Tobacco Use	☐ Yes	☐ No	If yes,_____packs(s) per day for _____years
Medical Marijuana/Drugs	☐ Yes	☐ No	Type and frequency_____
Exercise	☐ Yes	☐ No	Type and frequency_____
Caffeine	☐ Yes	☐ No	If yes, _____caffeinated drinks per day/week

Review of Systems

- ☐ Generally Healthy
- ☐ Recent Weight Gain or Loss
- ☐ Fevers
- ☐ Visions Problems (excluding glasses)
- ☐ Sinus Problems
- ☐ Hearing Problems
- ☐ Hearing loss
- ☐ Chest pain
- ☐ Varicose veins

Do you currently have any of the following?

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Heartburn/reflux
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Urgency
- ☐ Bladder infection
- ☐ Stomach pains
- ☐ Vaginal Discharge
- ☐ Irregular vaginal bleeding
- ☐ Pelvic pain
- ☐ Painful intercourse
- ☐ Breast lump
- ☐ Back pain
- ☐ Joint/muscle pain
- ☐ Depression/anxiety
- ☐ None of these

To the best of my knowledge, the above information is complete & correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient Signature_____ Date: _____