Overlake Obstetricians and Gynecologists, PC

Patient History Information

Last Name: _____ First Name: _____
Birth Date: _____ Today's Date: _____

Reason(s) for Visit: _____

CURRENT Health/Medical Problems:
Please describe any current medical problems and the care provider that you are seeing to treat this problem:

_____
_____
_____
_____

Past Medical History:
Have you ever had any of the following conditions? If so, please circle AND write details at the bottom of the list:

Bladder Problems	High Blood Pressure
Bleeding Disorders	Migraine Headaches
Blood Transfusions	Osteoporosis
Cancer	Psychiatric Problems
Deep Vein Thrombosis	Pulmonary Embolism
Depression/ Anxiety	Respiratory Problems/ Asthma
Diabetes	Seizure Disorder or Other Neurologic Problem
Heart Disease or Murmur	Stomach or Bowel Problems
Hepatitis	Thyroid
OTHER:	

Past Medical History Details:

_____
_____
_____

Health Care Maintenance Details:

Date of last Pap	
Date of last Mammogram	
Date of last DEXA/Bone Scan	
Date of last Colonoscopy	
Date of last Annual Blood Test (eg. Cholesterol, Complete Blood Count, etc.)	

Past Surgical History:

Type of Surgery:	Date:	Doctor/Location:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications and Supplements:
Please list all current medications and supplements, both prescription and over-the-counter, including dose and frequency if possible.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:
Please list all known allergies and reactions, including medications, foods, or environmental agents.

_____ _____
_____ _____
_____ _____
_____ _____

Family Medical History:
Has anyone in your family ever had any of the following conditions? If so, please circle and write details in the right column:

CONDITION:	**RELATION TO YOU/ DETAILS:**
Diabetes	
Heart Disease	
High Blood Pressure	
Uterine or Genital Cancer	
Breast Cancer	
Colon Cancer	
Prostate Cancer	
Bleeding Problems	
Multiple Births (twins, triplets)	
Birth Defects	
Genetic Diseases	
Osteoporosis	
Blood Clots or Deep Vein Thrombosis	
OTHER:	

Reproductive History:
First day of last menstrual period: _____ Your age at first period: _____
Usual interval between periods: _____ How long do your periods last: _____

Do you have pain with your periods?	YES	NO
Is there any bleeding between your periods?	YES	NO
Have you ever had a pelvic infection?	YES	NO
Have your ever had an abnormal pap smear?	YES	NO
Have you ever had genital warts?	YES	NO
Have you ever had genital herpes?	YES	NO

If your answer is "YES" to any of the above questions, please describe below:
_____
_____
_____

Do you currently use any method of birth control/pregnancy prevention? _____ Type:_____
List other methods you have used: _____

Pregnancy History:

Total # of Pregnancies:	**# of Miscarriages:**	**# of Abortions:**	**# of Deliveries:**	**Living Children:**

Date	**Gender**	**Name**	**Birth Weight**	**Anesthesia?**	**Pregnancy/Labor Details?**	**Location**

Social History:

Substance Use:

Do you smoke cigarettes?	YES	NO	AMOUNT:
Do you drink alcohol?	YES	NO	AMOUNT:
Do you consume caffeine?	YES	NO	AMOUNT:
Do you use any recreational drugs?	YES	NO	TYPE/AMOUNT:

Exercise:

How often do you exercise per week? _____

What types of exercise do you prefer? _____

Safety:

Do you feel safe at home? _____

Do you feel safe in ALL of your current relationships? _____

_____

Review of Systems

Please complete this form for each visit to your care provider. Please circle ANY symptom that you are currently experiencing or have experienced in the last ONE YEAR. Give details whenever possible.

Constitutional

Fatigue	Fever	Chills	Body Aches
Night Sweats	Weight Gain	Weight Loss	Loss of Appetite

Eyes

Discharge from Eye	Eye Discomfort	Impaired Vision	

Head-Ears-Nose-Throat

Headaches	Lightheadedness/ Fainting	Recent Head Injury	Nasal Congestion
Nose Bleeding	Nasal Discharge	Decreased Hearing	Sinus Pain
Sore Throat	Dental Problems	Ringing in Ears	

Breasts

Lumps	Tenderness	Dimpling	Abnormal Changes in Breast Size
Redness	Nipple Discharge	Swelling	

Cardiovascular

Chest Pain	Irregular Heart Beats	Rapid Heart Rate	Leg/ Ankle/ Foot Swelling
Varicosities			

Respiratory

Shortness of Breath	Wheezing	Tuberculosis Exposure	Cough
Hoarseness			

Gastrointestinal

Nausea	Hemorrhoids	Abdominal Pain	Diarrhea
Constipation	Vomiting	Bloating	
Change in Stools	Heartburn	Jaundice	

Genitourinary

Urinary Urgency	Difficulty Urinating	Absence of Menstrual Period	Pain with Periods
Urinary Frequency	Pain with Urination	Irregular Menstrual Periods	Significant PMS Symptoms
Blood in Urine	Pain with Intercourse	Heavy Bleeding with Periods	Genital Sores
Leakage of Urine	Abnormal Vaginal Discharge	Bleeding After Intercourse	Decreased Sex Drive

(OVER)

Integumentary

Rash	New Skin Lesions	Itching	Changes to Existing Lesions or Moles
Skin Dryness	Acne	Hair Growth Change	

Neurologic

Muscular Weakness	Seizures	Tingling or Numbness	Loss of Balance
Difficulty Concentrating	Memory Difficulties		

Musculoskeletal

Joint Pain	Joint Swelling	Back Pain/ Injury	Muscle Pain
Limitation of Motion	Muscular Weakness		

Endocrine

Excessive Urination	Excessive Thirst		

Psychiatric

Depression	Anxiety	Difficulty Sleeping	Thoughts of Hurting Yourself or Others

Hematology-Lymphatic

Lymph Node Enlargement or Tenderness	Easy Bruising	

Allergic-Immunologic

Hayfever/ Seasonal Allergies	Hives	Frequent Illness