DOWNRIVER OBSTETRICS & GYNECOLOGY
HISTORY FORM

Please complete this medical history form & give it to the nurse when you are called in to the exam room.

Name_____ DOB_____ Today's Date_____

Allergies: (please write "none" if you have no allergies)

Allergy to: (medications, latex, environmental, etc) Reaction (hives, rash, etc)

_____

_____

_____

Family History: (List any illnesses your immediate family has: heart disease, cancer, bleeding disorders, stroke, etc.)

Illness Relation to you

_____

_____

_____

Gynecological History:

☐ Abnormal Pap ☐ Infertility ☐ Fibroids ☐ Abnormal periods ☐ Pelvic Pain

☐ Endometriosis ☐ STD's_____ ☐ Cancer ☐ Other_____

Date of Last Pap Smear_____ Date of Last Mammogram_____

OB History:

# of Pregnancies_____ # of Miscarriages_____ # of Abortions_____ Currently pregnant? Y N

Delivery Date _____ Sex ___ Wt._____ Vag/C-sec?_____Complications_____

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Surgeries:

Type of surgery Date Type of surgery Date

_____

_____

_____

Medical History: (please check any that apply)

☐ Heart Disease/High Blood Pressure/Stroke
☐ Depression / Psychological
☐ Lung Disease (TB, Asthma, Pneumonia, CF)
☐ Thyroid Disorder
☐ Diabetes
☐ Stomach Problems / Ulcers / Reflux
☐ Jaundice / Hepatitis
☐ Cancer
☐ Seizures / Epilepsy
☐ Speech / Hearing Problem
☐ Other: _____

Social History:

How often do you drink? (Circle one) Socially Daily Never

Do you smoke? _____ If so, how many packs per day?_____

Do you or have you used any street drugs? _____ If so, which drugs?_____

Please include anything else you think we should know?_____

_____

Current Medications, including Birth Control: (Please write "none" if you are not taking any medications)

Drug Name Dosage Directions

_____

_____

_____

_____

Immunization History: (Check if you have you received the following vaccines)

☐ Gardasil (HPV) ☐ Tdap (Tetanus/Diptheria/Pertusis booster)

Primary Care Physician: _____ Referring Physician:_____

Name of Pharmacy Location Phone/Fax if known

_____

Print Name:_____ Signature: _____ Date_____