



Mary Washington

Obstetrics and Gynecology

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Patient form

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Past Medical History *Please check all that apply:*

- Abnormal Bleeding
- Anemia/Hypertension
- Anxiety/Depression
- Asthma/Migraines
- Blood Transfusion/Pelvic Pain
- Cardiovascular Disease/Sexual Assault
- Cervical Dysplasia/Stroke
- Clotting Disorder/Seizures
- Diabetes/Thyroid Disorder
- Endometriosis/Traumatic Injury
- Esophageal Reflux/Varicosities

Please list any other injury/illness: _____

Have you ever had CANCER? _____ *If yes, when?* _____ *Type?* _____

Please list all allergies to medications and reactions: () No allergies

Please list all prescription and over-the-counter medications, including herbal supplements:

Medications	Dose/Strength	How taken	Times per day

Do you currently have or have you ever had any problems with the following:	No	Yes	Date of diagnosis and treatments
High blood pressure			
Heart problems			
Thyroid disorder			
Diabetes			
Liver problems/Hepatitis			
Lung problems/Asthma			
Kidney problems (UTIs, stones)			
Autoimmune disorder/ Arthritis/Lupus			
Gynecological problems (STDs, Fibroids, infertility, IUD, Cervical biopsy, D&C)			
Psychological problems (depression, anxiety)			
Neurological problems (stroke, headache, seizure)			
Other problems? List:			

Surgical History:

Have you ever had surgery? _____ *If yes, list below:*

Date: _____ Surgery: _____

Problems: _____

Family Health History *Please check all that apply:*

- | | |
|---|---|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Clotting Disorders | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Colon Cancer | |

Other: _____

Reproductive History:

Last Menstrual Period: _____

Method of Contraception: _____ Do you desire contraception? Yes No

Total Pregnancies: _____ Full Term: _____ Pre-Term (under 38 weeks): _____

Miscarriages: _____ Abortions: _____ Ectopic: _____ Stillborn: _____

C-Section: _____ Current living children: _____

Problems during previous pregnancies (check):

Hypertension: _____ Diabetes: _____ Toxemia: _____ Pre-Term Labor: _____

Excessive Blood Loss: _____ Blood Transfusion: _____

General Health: *Please check all that apply:*

Alcohol Use: Never Rarely Occasionally Moderately

Tobacco Use: Never Former Current Packs per day: _____

Date of last Pap Smear: _____

Date of last Mammogram: _____

Date of last Colonoscopy: _____

Date of last Bone Density: _____



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