FOLSOM OB/GYN

New Patient Personal & Family History

Date: _____

Name: _____ Age: _____

Who referred you to our office? _____

What is the reason for your visit today? _____

_____

_____

Are there any other problems you would like addressed? _____

_____

_____

Please list any allergies to medications (include reaction).
Also include severe food, or environmental allergies including latex.

_____

_____

Please list any medications (including dosage and how you are taking them:

_____

_____

Have you had any of the following problems?

☐ Heart/Cardiovascular Disease	☐ Triglycerides	☐ Elevated Cholesterol
☐ Coronary Artery Disease/MI	☐ Hypertension	☐ Gall Bladder Disease
☐ Diabetes Type I	☐ Diabetes Type II	☐ Colon Polyps
☐ GERD (Reflux)	☐ Hepatitis	☐ Thyroid Disorder
☐ Irritable Bowel Syndrome	☐ Alzheimer's	☐ Kidney Disease
☐ Attention Deficit disorder	☐ Infertility	☐ Stroke
☐ Incontinence	☐ Fibromyalgia	☐ Multiple Sclerosis
☐ Factures	☐ Arthritis	☐ Anemia
☐ Parkinson's Disease	☐ Osteoporosis	☐ Lupus
☐ Allergies	☐ Headaches	☐ Cancer
Seasonal ☐ Year Round ☐	Type: _____	Type: _____

Have you been diagnosed by a physician for any diseases or medical conditions that are not listed above? _____

_____

Pregnancy History (please indicate number if each)

____ Full Term ____ Premature Deliveries____ Abortions ____ Miscarriages

Any complications during your pregnancies? _____

_____

Gynecological History

First day of last menstrual period: _____ Are periods regular? ☐/☐

Are you having any problems with your menstrual cycles? _____

What is your current form of **Birth Control**? _____

How old were you when you had your first period? _____

If you have gone through **menopause**, how old were you had your last period?

When was your last **pap smear**? _____ Ever had an abnormal pap? ☐/☐

If yes, what was the outcome of the follow up testing? _____

When was your last **mammogram**? _____ Any abnormal Mammograms? ☐/☐

If yes, what was the outcome of the follow up testing? _____

When was your last **Dexa** (bone scan)? _____

What were the results? _____

When was your last **colonoscopy**? _____

What were the results? _____

When is your one next due? _____

Please list surgeries you have had and when they were performed

Surgery	**Date**
_____	_____
_____	_____
_____	_____

Family History
Please check any diseases that a member of your family has been affected by, and list which members were affected.

☐ Hypertension _____

☐ Heart Disease _____

☐ Intestinal Disease _____

☐ Osteoporosis _____

☐ Lupus _____

☐ Arthritis _____

☐ Diabetes _____

☐ Alzheimer's _____

☐ Stroke _____

☐ Parkinson's disease _____

☐ Cancer (please indicate type and age of diagnosis)

_____

Social History

Occupation: _____

Marital Status: _____

Number of children and ages: _____

Hobbies: _____

Exercise (please indicate type and frequency): _____

Do you smoke? ☐/☐ If yes, how much? _____

If you smoked in the past, when did you quit? _____

Do you drink alcohol? ☐/☐ If yes, how much? _____

Do you use other drugs? ☐/☐ If yes, how much? _____

Do you live in a safe/supportive home? ☐/☐

If no, please explain: _____

Do you now, or have you ever suffered from any psychiatric disorders? (I.e. anxiety disorder, eating disorder, depression)? ☐/☐

If yes, please explain: _____

Do you now, or have you ever had any sexually transmitted diseases? ☐/☐

If yes, please explain: _____

Do you now, or have you ever had any communicable diseases? (I.e. hepatitis, Lyme disease, tuberculosis)? ☐/☐

If yes, please explain: _____

Is there anything else you would like the doctor to know about you?

_____

_____

_____