

Desert Bloom OB/GYN

Patient Name _____ Date of Birth _____ SS# _____

SOCIAL HISTORY

Today's Date _____
 Usual Weight _____
 Hobbies _____
 Exercise/Recreation _____
 Smoking/amount per day _____
 Alcohol/amount per week _____
 Caffeine/amount per day _____
 Street drugs/type & amount per day _____

| | Medication | Date Started | Date Stopped |
|----|------------|--------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

PLEASE INDICATE ANY PERSONAL HISTORY BELOW:

| | | |
|--|--|---|
| <p><input type="checkbox"/> Constitutional Symptoms</p> <p>Good general health lately No Yes Recent weight change No Yes Fatigue No Yes</p> <p><input type="checkbox"/> Eyes</p> <p>Eye Disease or injury No Yes Wear glasses/contact lenses No Yes</p> <p><input type="checkbox"/> Ears/Nose/Mouth/Throat</p> <p>Chronic sinus problem or rhinitis No Yes Sore throat or voice change No Yes</p> <p><input type="checkbox"/> Cardiovascular</p> <p>Heart trouble No Yes Chest pain or palpitation No Yes Swelling of feet, ankles or hands No Yes</p> <p><input type="checkbox"/> Respiratory</p> <p>Shortness of breath No Yes Wheezing No Yes</p> <p><input type="checkbox"/> Gastrointestinal</p> <p>Loss of appetite No Yes Change in bowel movement No Yes Nausea or vomiting No Yes Frequent diarrhea No Yes Constipation No Yes Rectal bleeding or blood in stool No Yes Abdominal cramping No Yes</p> <p><input type="checkbox"/> Genitourinary</p> <p>Frequent urination No Yes Burning or painful urination No Yes Blood in urine No Yes Incontinence (leaking urine) No Yes Kidney stones No Yes Sexual difficulty No Yes</p> | <p><input type="checkbox"/> Gynecological</p> <p>Pain with periods No Yes Irregular periods No Yes Vaginal discharge No Yes Bleeding/spotting between periods No Yes Night sweats or hot flashes No Yes</p> <p>Number of pregnancies _____ Number of miscarriages _____ Terminations/Abortions _____ Vaginal deliveries _____ C-Sections _____ Last Pap Smear date _____ Age period began _____ How many days does period last? _____ How many days between periods? _____ Sexually Transmitted Disease _____ History of Abnormal Pap _____ Last Menstrual Period (first day) _____ Birth Control Method _____</p> <p><input type="checkbox"/> Musculoskeletal</p> <p>Joint pain stiffness or swelling No Yes Muscle pain or cramps No Yes Back Pain No Yes</p> <p><input type="checkbox"/> Integumentary (skin, breast)</p> <p>Rash or itching No Yes Varicose veins No Yes Breast pain No Yes Breast lump or discharge No Yes Breast cancer history No Yes</p> <p><input type="checkbox"/> Neurological</p> <p>Frequent or recurring headaches No Yes Light headed or dizzy No Yes Convulsions or seizures No Yes</p> | <p><input type="checkbox"/> Psychiatric</p> <p>Nervousness No Yes Depression No Yes Insomnia No Yes</p> <p><input type="checkbox"/> Endocrine</p> <p>Glandular or hormone problem No Yes Excessive thirst or urination No Yes</p> <p><input type="checkbox"/> Hematologic/Lymphatic</p> <p>Bleeding or bruising tendency No Yes Anemia No Yes Phlebitis No Yes Past transfusion No Yes Enlarged glands No Yes</p> <p><input type="checkbox"/> Allergic/Immunologic</p> <p>History of skin reaction or other adverse reactions to:</p> <p>Drugs or medications _____ _____ _____</p> <p>Known food allergies _____ _____ _____</p> <p>Environmental allergies _____ _____ _____</p> <p>Please list all operations and year these occurred: _____ _____ _____ _____ _____</p> |
|--|--|---|

FAMILY HISTORY

Has any blood relative had any of the following: Circle "no" or "yes." If yes, please explain.

| | | | | | | | |
|---------------------|----|-----|-------|-------------------|----|-----|-------|
| Cancer | no | yes | _____ | Stroke | no | yes | _____ |
| Tuberculosis | no | yes | _____ | Epilepsy | no | yes | _____ |
| Diabetes | no | yes | _____ | Allergies | no | yes | _____ |
| Heart disease | no | yes | _____ | Anemia | no | yes | _____ |
| High blood pressure | no | yes | _____ | Bleeding tendency | no | yes | _____ |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Date _____

Signature of Patient, Parent or Guardian _____