CARE FOR YOU OB-GYN, PLLC
PATIENT HISTORY QUESTIONNAIRE

Name:_____**Birthdate**:_____/_____/_____Today's Date: ____/_____/_____

Name of Primary Care Physician: _____Who referred you?_____

Reason for visit: _____**DRUG ALLERGIES**: _____

Number of Pregnancies:_____Number of Children Born:_____

Have you or anyone in your family (Mom, Dad, siblings, grandparents) had the following:
(Use MGM for maternal grandmother, PGF for paternal grandfather, etc.)

	SELF	OTHER FAMILY MEMBERS
Alzheimer's		
Asthma		
Birth Defects		
Bleeding Disorders		
Blood Clot History		
Breast Cancer		
Other Cancer		
Diabetes		
Epilepsy		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Stroke		
Twins		

What Surgeries have you had?

SURGERY	DATE
_____	

Have you ever had a DXA Scan?
Y N

Results: Normal ___
Osteopenia ___Osteoporosis ___

Please Circle any of the following YOU have had:

Anemia	Hepatitis (A/B/C)	Mitral Valve Prolapse	-Human Papilloma Virus
Blood Transfusion	High Cholesterol	Sexually Transmitted Diseases:	-Syphilis
Bowel Problems	Kidney Stones	-Chlamydia	Substance Abuse
Depression	Lung Disease	-Genital Warts	Thyroid Disease
Fibromyalgia	Lupus	-Gonorrhea	Ulcers
Gallbladder Disease	Migraines	-Herpes	Urinary Tract Infections

How old were you when you had your first menstrual cycle? _____
Are your menstrual cycles regular? Y N How many days apart are they? _____ Duration? _____
Are they heavy? Y N Severe cramping? Y N
When was the first day of your last menstrual cycle? _____
When was your last Pap smear? _____
Have you ever had an abnormal Pap smear? Y N When?_____ How was it treated?_____
When was your last mammogram? _____

Have you ever had intercourse? Y N
How many sexual partners have you had in the last 6 months? _____
Are you sexually active with men? Y N women? Y N or both? Y N
What method of contraception do you or your partner use? _____
Has your partner had a vasectomy? Y N

Do you smoke cigarettes? Y N If so, how many per day? _____
How many servings do you consume each week of: Beer_____ Wine_____ Hard Liquor_____
How many servings of caffeine do you consume each day? _____
What vitamins/herbal supplements do you take regularly? _____
Do you take Calcium Supplements? Y N If so, how much per day? _____mg.

Please list the name, dosage and dosing schedule of any medication you currently take:

_____ _____

_____ _____

Please list your pharmacy name and phone number: _____

Patient's Signature: _____ **Date:** _____

Provider's Signature: _____ **Date:** _____