

**GIFTS FROM GRACE OBGYN
PAST FAMILY/MEDICAL/SOCIAL HISTORY/ROS**

PAIENT NAME: _____ DATE: _____
Last First Middle

Nickname: _____ Date of Birth: _____ Age: _____
MM/DD/YYYY

ALLERGIES: [] NO KNOWN ALLERGEIS

Medication / Food / Environmental	Reaction (hives, rash, SOB, etc.)

MEDICATIONS: Please list all medications including OTC (over the counter), Prescriptions & Herbal.

Drug name	Dosage	Date started	Drug name	Dosage	Date started

OPERATIONS (in office or Hospital)/HOSPITALIZATIONS: Medical/Surgical/Accident [] NONE

REASON	DATE	HOSPITAL/Dr's Office

PAST MEDICAL HISTORY: (Please check all that apply to you in the past) it helps us take better care of you.

Anemia	High Blood Pressure	Recurrent UTI's	Fibroids
Abnormal Wt. Gain	Heart Disease	Kidney Stones	Benign Breast Mass
Abnormal Wt. Loss	Varicose Veins	Kidney Disease	Abn Uterine Bleeding
Depression/Anxiety/Bipolar	Stroke	Hepatitis	Uterine Problems
Hearing/Vision Loss	Mitral Valve Prolapse	Irritable Bowel	Bartholin's Gland Cyst
Constipation	Blood Clots	Crohn's Disease	Recurrent Vaginitis
Migraines	Elevated Cholesterol	Lupus	PCOS
Hemorrhoids	Hyperthyroid	Arthritis	Tuberculosis
Asthma	Hypothyroid	Sickle Cell Trait/Disease	Diabetes
Chronic Use of Steroids	COPD	Seizures	Use of Anticoagulant
Interstitial Cystitis	Osteoporosis	Breast Cancer	Uterine Cancer
Ovarian Cancer	Cancer: _____	Other: _____	Other: _____

Patient Name: _____ DOB: _____ Date: _____

FAMILY HISTORY: [] Adopted (no family history available) [] NONE

Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased-cause	Age	Father <input type="checkbox"/> Living <input type="checkbox"/> Deceased-cause	Age
Siblings: M/F	Deceased	Age	Children: M/F

Please indicate any Family History:

ILLNESS	YES	WHICH RELATIVE & ONSET AGE	PROVIDER NOTES
Cancer			
Diabetes			
Thyroid			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Stroke			
Hepatitis			
Kidney Disease			
Arthritis			
Osteoporosis			
Depression/Anxiety/Bipolar			
Alzheimer's Disease			
other			

Gynecologic History

Menstrual History		Menopause History	
Age at first period?		Age of last period?	Date:
Duration of period?	Days	Reason for menopause <input type="checkbox"/> Chemo <input type="checkbox"/> Natural <input type="checkbox"/> Surgical	
Interval between periods?	Days		
Age at first birth:	Date of last period:	Date of last Pap smear:	
Date of last mammogram:	Date of last Bone Density:	Do you do self breast exams?	
Have you been exposed to (DES)?			
Current method of birth control: <input type="checkbox"/> None <input type="checkbox"/> IUD <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Condoms <input type="checkbox"/> Depo Provera <input type="checkbox"/> other			

PREGNANCY HISTORY:

Full Term (>37 weeks)		Live at Birth		Miscarriages	
Preterm (<37 weeks)		Live at Present		Abortions	
Cesarean Sections		Vaginal Deliveries		Ectopic	

DATE	SEX	WEEKS	WEIGHT	VAG OR C/S	HR IN LABOR	COMPLICATIONS

Patient Name: _____ DOB: _____ Date: _____

GENETIC HISTORY: (OB PATIENT'S ONLY) Please check all that apply to self, Father of the baby or either family

S.I.D.S.	Maternal Age >34	Thalassemia	Down's Syndrome
Tay Sacs	Mental Retardation/Autism	Hemophilia	Cystic Fibrosis
Fragile X	Sickle Cell Trait/Disease	Muscular Dystrophy	Neural Tube Defect
S.M.A.	Congenital Heart Disease	Huntingdon's Chorea	Medications/Street Drugs
Maternal Metabolic Disorders	Child born w/ birth defects	Other Inherited/Genetic defect	

SOCIAL HISTORY:

Description	Yes	No	Description	Yes	No
Smoke Detectors			Do you have a Living Will?		
Firearms Safe			Do you have a Durable Power of Attorney?		
Do you use your seatbelt?			Do you agree to a blood transfusion?		
Have you been sexually abused or hurt?			Are you an organ donor?		
Do you travel outside the U.S.?			Highest Education <input type="checkbox"/> HS <input type="checkbox"/> College/Tech <input type="checkbox"/> Graduate Degree		
Primary Language:	Do you require an Interpreter? Who?				
What is your Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Prev. Divorced Married <input type="checkbox"/> Prev Widowed Married					
Husband or Significant Other Name:					
Tobacco Use: <input type="checkbox"/> None <input type="checkbox"/> Quit When? How Long have you smoked? Yrs Amount: packs/day					
Are you exposed to 2 nd hand smoke?			Where/Who?		
Alcohol Use: <input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely Amount: glasses/_____ Type:					
Caffeine Use: <input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda <input type="checkbox"/> Other: Amount per day:					
Activity Level: <input type="checkbox"/> Moderate <input type="checkbox"/> Sedentary <input type="checkbox"/> Vigorous Amount per week: Type:					
Diet History: <input type="checkbox"/> Diabetic <input type="checkbox"/> Healthy <input type="checkbox"/> Vegetarian <input type="checkbox"/> Poor					
Religious Affiliation: <input type="checkbox"/> Jewish <input type="checkbox"/> Jehovah's Witness <input type="checkbox"/> Christian <input type="checkbox"/> Other:					
Animals In the home: <input type="checkbox"/> Dog <input type="checkbox"/> Bird <input type="checkbox"/> Cat <input type="checkbox"/> Other				Do you change the litter?	

Immunization/Test

	DATE		DATE
Tetanus-Diphtheria Booster		Influenza Vaccine (Flu Shot)	
Hepatitis A Vaccine		Hepatitis B Vaccine	
Varicella (chicken Pox) Vaccine		Measles-Mumps-Rubella (MMR)	
TB Skin Test: Result:			

Are you new to this practice? Yes / No Who is your PCP? _____

Who referred you to us? _____

Reason for your Visit today: [] Annual Well Woman Exam [] Problem Visit [] New Obstetrical Exam

Please describe you problem(s), also telling us where it's located, how long you've experienced it and anything you have done to relieve the issue:

Patient Name: _____ DOB: _____ Date: _____

REVIEW OF SYSTEMS: Please check any of the following symptoms that apply to you now.

System/Description	Yes	NO	Not Sure	Provider Notes:
Constitutional:				
Fever				
Weight loss				
Weight gain				
Fatigue				
Change in height				
Eyes:				
Double Vision				
Vision Changes				
Glasses/Contacts				
Ear, Nose, and Throat:				
Earaches				
Ringing in ears				
Hearing problems				
Sinus problems				
Dental problems				
Cardiovascular:				
Chest pain or pressure				
Difficulty breathing on exertion				
Swelling of legs				
Rapid or irregular heartbeat				
Respiratory:				
Shortness of breath				
Chronic cough				
Wheezing				
Gastrointestinal:				
Frequent diarrhea				
Bloody stool				
Nausea/vomiting/indigestion				
Constipation				
Involuntary loss of gas or stool				
Genitourinary:				
Blood in urine				
Pain with urination				
Strong urgency to urinate				
Frequent urination				
Urine loss when coughing or lifting				
Abnormal bleeding				
Painful periods				
Premenstrual syndrome (PMS)				
Painful intercourse				
Abnormal vaginal discharge				

Patient Name: _____ DOB: _____ Date: _____

ROS Continued				
Musculoskeletal:	YES	NO	Not Sure	Provider Notes:
Muscle or joint pain				
Muscle weakness				
Skin:				
Rash				
Sores				
Dry skin				
Moles (growth or changes)				
Breasts:				
Pain in breast				
Nipple discharge				
Lumps				
Neurologic:				
Dizziness				
Seizures				
Memory loss				
Frequent headaches				
Psychiatric:				
Anxiety				
Depression				
Endocrine:				
Hair loss				
Hot flashes				
Abnormal thirst				
Hematologic/Lymphatic:				
Frequent bruises				
Cuts don't stop bleeding				
Enlarged Lymph nodes (glands)				
Allergic/ immunologic				
Seasonal allergies				
Latex allergy				
Other allergies				
HIV Positive				

Form Completed By: [] Patient [] Office staff [] Provider [] Other: _____

Patient Signature: _____

Date Reviewed: _____ Provider Signature: _____

Annual Review of History

Date Reviewed: _____ Provider Signature: _____

Date Reviewed: _____ Provider Signature: _____

Date Reviewed: _____ Provider Signature: _____

Patient Name: _____ DOB: _____ Date: _____

Gifts from Grace OB/GYN

CONFIDENTIAL INFORMATION:

Although this is sensitive information, it may be very important to your care. We ask that you answer all questions honestly. I agree to have this information included in my social history.

Signature

Alcohol: NONE

Age started _____ Sought treatment **Y / N** Involved in treatment at present: **Y / N**

Drugs: NONE

Using street drugs: **Y / N** Type: ____ cocaine ____ marijuana ____ ecstasy ____ other: _____

Sought treatment: **Y / N** Frequency: Weekly Monthly Occasionally

Psychiatric: NONE

History of suicidal thoughts: **Y / N** Treated for psychiatric problem: **Y / N**

Diagnosis: _____ Age of diagnosis: _____

Family history of psychiatric problem: **Y / N** Relationship: _____

Abuse: NONE

History of abuse as a child: **Y / N** Perpetrator: _____ physical sexual verbal

History of domestic violence: **Y / N** Perpetrator: _____ physical sexual verbal

Is the perpetrator in the home? **Y / N** Is there a restraining order? **Y / N**

Within the past year, or during a pregnancy, have you been hit, kicked or physically hurt? **Y / N**

Are you in a relationship with a person who has threatened you or physically hurt you? **Y / N**

Has anyone forced you to have or perform sexual activities that made you feel uncomfortable? **Y / N**

Incarceration: NONE

History of incarceration: **Y / N** From _____ to _____ Convicted of: _____

Sexual Practices:

Sexually active: **Y / N** # of current partners _____ Condom Use: **Y / N**

Sexual orientation: Bisexual Heterosexual Homosexual

Birth Control at present:

_____ None _____ Contraceptive patch _____ Rhythm/Natural Family Planning

_____ Depo Provera _____ Nuva Ring _____ Spermicide

_____ IUD _____ Oral Contraceptive _____ Tubal Ligation

_____ Hysterectomy _____ Post Menopausal _____ Vasectomy

_____ Other _____

Sexually Transmitted Infections: NONE

HIV: Positive Negative Unknown

History of Sexually Transmitted Infections:

_____ Chlamydia _____ Hepatitis B _____ Human Papilloma Virus (HPV)

_____ Gonorrhea _____ Hepatitis C _____ Syphilis

_____ Genital Warts _____ Herpes (HSV)

Patient's Signature _____

Provider Signature _____ Date _____