Conway Obstetrics & Gynecology Clinic, P.A. 1-1-2013

PATIENT INFORMATION FORM

MEDICAL HISTORY

(PLEASE GIVE YOUR MEDICAL RECORDS TO THE RECEPTIONIST)

Name:	Date of birth:
Phone number:	Primary care physician:

MEDICAL INFORMATION

ILLNESS	SELF	FAMILY	ILLNESS	SELF	FAMILY
DIABETES			CANCER		
HIGH BLOOD PRESSURE			ANEMIA		
HEART ATTACK			BLOOD CLOTS LUNG/LEGS		
STROKE			DEPRESSION		
SEIZURES			ANXIETY		
ASTHMA			PSYCHIATRIC DISORDERS		
THYROID PROBLEMS			HIGH CHOLESTEROL		
UTERINE OR GENITAL CANCER			HEART DISEASE		
BREAST CANCER			KIDNEY INFECTION/STONES		
LIVER DISEASE			LUNG DISEASE		
ANOREXIA/BULIMIA			STOMACH, INTESTINAL DISORDERS, GERD		

SURGICAL HISTORY

MM/DD/YY	SURGICAL HISTORY

CURRENT MEDICATIONS: Please list ALL. Prescribed and Over the Counter as well. Please use back of form if more room is needed.

MEDICATION	DOSE	FREQUENCY	PRESCRIBED BY

ALLERGIES- Please list ALL known allergies or NONE.

ALLERGY	REACTION/SYMPTOM
LATEX:	
DRUGS:	

OBSTETRICAL HISTORY INCLUDING ALL PREGNANCIES (ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES ALSO)

MM/DD/YY	DURATION OF PREGNANCY	TYPE OF DELIVERY	COMPLICATIONS MOTHER/INFANT	INFANT SEX	INFANT WEIGHT

Date of last menstrual period: How long does it last? ___________ Age of last period: _______________
How many days between periods? Date of last Pap smear: ___________________________________
History of abnormal Pap? YES NO Place where Pap smear was performed: ___________________________
Current method of birth control: ____
Any breast surgery? ____
Last mammogram and place where procedure was performed: __________ Year: ___________________
Have you ever had an abnormal mammogram? YES NO Location? ________________________________
Bone Density and place where procedure was performed: ___________________ Year: ________________________
Dexagram and place where procedure was performed: ____________________ Year: ________________________
Date of last Colonoscopy: ________ Results: _____ Physician who performed colonoscopy: ___________________

SOCIAL HISTORY:

Do you smoke Yes ☐ No ☐ packs per day ___/cigarettes per day ___How many years: ___________
Drink alcohol Yes ☐ No ☐
Use street drugs Yes ☐ No ☐ Type__________ Amount ____________Last date used________________
Occupation: _______________________________________ Employer: _______________________________________
Marital status: Married ☐ Single ☐ Widow ☐ Divorced ☐ ____ Separated ☐ ____
Do you have a sexual partner: Yes ☐ No ☐

Patient name (print) **Date**

Patient signature