Memphis Obstetrics & Gynecological Association, P.C. (MOGA | MCW | WPG | WHS)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____

Allergies: _____

Do you have a **LATEX Sensitivity / Allergy**: Yes: □ No: □ **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

MEDICATIONS: Please list ALL medications that you take, the strength, and how often you take them

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY (Name and Number): _____

OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE (other than MOGA)

Provider Name	**Specialty (ie: PCP, Cardio)**	**Phone Number:**

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when

□ Influenza (Flu) / Date:	□ Tetanus / Date:
□ Pneumonia / Date:	□ Tdap (Tetanus, Diptheria & Pertussis)/ Date:
□ HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1st shot) Dates (Approx. date is ok): #1 _____ #2 _____ #3 _____	

FAMILY HISTORY: Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

□ Adopted: Family history unknown	□ Hypertension/ High blood pressure / relation:	
□ Blood clotting disorder / relation:	Malignant neoplastic disease/Cancer: (please list relative)	
□ Cerebrovascular accident (CVA) / Stroke	□ Breast: _____	□ Uterine: _____
□ Cystic fibrosis / relation:	□ Colon: _____	□ Other: _____
□ Diabetes /relation:	□ Ovarian: _____	
□ Disorder of thyroid/ relation:	□ Myocardial Infarction (heart attack)	
□ Heart disease / relation:	□ Substance abuse:	
□ Hypercholesterolemia / relation:	□ Other Family History:	

SOCIAL HISTORY: Provide the following information about **YOURSELF**

Tobacco or Cigarette Use: □ Never Smoked □ Former Smoker - Date Quit _____ □ Current Smoker - # per day ____ # of years_____	Do you use recreational drugs? □ Yes □No If yes, which one(s) and how often? _____
Relationship Status: □ Single □ Married □ Widowed □ Divorced □ Separated	Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual
Lives □ alone or □ with others	Are you currently in a situation or relationship that makes you feel unsafe or threatened? □Yes □No
Education (highest grade completed): _____	If yes, explain _____
Occupation: _____	Do you refuse blood products or medical treatment of Any kind because of religious beliefs? □ Yes □ No
Work Status: □Part-time □Full-time □Retired □Unemployed □Disabled	Explain:_____
Do you drink alcoholic beverages? □ Yes □ No	Do you have an advanced directive: □ Yes □ No
If yes, how much? _____	Other: _____

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CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____

SURGICAL HISTORY: Please list surgeries or procedures and **provide dates (**month and/or year is fine**)**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

GYN History:

Birth control method: _____	□ Infertility
Are you sexually active? □ Yes □ No	□ Polycystic Ovarian Syndrome
If no, have you ever been sexually active? □ Yes □ No	Age of Menopause _____
Age of first sexual activity: _____	Postmenopausal Bleeding? □ Yes □ No
Number of sexual partners in lifetime: _____	Taking hormone replacement therapy? □ Yes □ No
Menses: (**only complete if still having periods**)	Have you ever had any of the following infections?
Age of first period _____	□ Chlamydia □ Gonorrhea □ Herpes □ HIV □ Syphilis
□ Regular (21-35 days apart) □ Irregular	Abnormal Pap Smear: □ Yes - date: _____ □ No
Duration of menses: _____ days	□ Colposcopy/Biopsy of cervix Date: _____
Menstrual Flow: □Mild □Moderate □Severe	□ Cryo/Date:_____
	□ LEEP/Date: _____ □ CKC/Date: _____

Last **Pap Smear**: Date:_____ Provider: _____
Last **Mammogram**: Date: _____ Facility: _____
Last **Complete Physical Exam with Primary MD**: Date: _____ Provider Name: _____
Last **DEXA Scan** (**Bone Density**): Date: _____ Facility: _____
Last **Colonoscopy**: Date: _____ Provider Name: _____

OB History: (Please list details of each pregnancy below)

Total Pregnancies: ____ Full term: ___ Preterm: ___ Elective abortions: ___ Miscarriages: ___ Ectopics: ____ Multiple births ____ Living ____

Date	Weeks Delivered	Birth wt	Sex	Type of Delivery & Anesthesia	Preterm Labor or Other Complications

PAST MEDICAL HISTORY: Please check illnesses or conditions **YOU** have had.

□ Autoimmune Disorder	**Heart Disease**:
Blood disorders: □ Anemia	□Atrial Fibrillation □Congestive Heart Failure □CAD
□ DVT (Blood Clot in leg) □ PE (clot in lung)	□High Cholesterol □High Blood Pressure (HTN)
□ Blood Transfusion: Date(s): _____	**Kidney Disease:** □ Kidney Stones □ Other_____
Sickle Cell : □ Trait □ Disease	**Lung Disease**: □Asthma □COPD □Pneumonia
□ Breast Problems (specify) _____	Do you use a CPAP machine for sleep apnea? □ Yes
Cancer: □Breast □Ovarian □Uterine □Colon	**Musculoskeletal**:
□ Other Cancer(specify) _____	Arthritis: □ Osteoarthritis □ Rheumatoid Arthritis
□ Diabetes □ Gestational diabetes (in pregnancy)	□ Osteopenia □ Osteoporosis □ Other _____
□ Eating Disorder	**Neurological**: □ Migraine Headaches
Gastrointestinal Disorders:	□ Seizure Disorder/Epilepsy □ Stroke
□ Acid Reflux/ GERD □ Celiac Disease □ Cirrhosis	**Psychological:** □Anxiety □Bipolar □Depression □ADD
□ Crohn's Disease □ Diverticulitis □ Hepatitis/Liver Disease	**Thyroid Disorder**: □Goiter □Underactive □Overactive
□ Irritable Bowel □ Ulcerative Colitis	**Varicella**/Chicken Pox: □ Had Virus **or** □ Had Vaccine
□ Other (specify): _____	

Patient Signature: _____ Date:_____