ADVANCED OB-GYN
Obstetrics & Gynecology
230 Michigan St. NE, Suite 102, Grand Rapids, MI 49503 616-971-0060

Name:	
Doctor's Initials:	Date:

MEDICAL HISTORY

Full Name:________________________ Name you preferred to be called:________________

Date of birth:__________________ Age:______ Date of appointment:________________________

Primary Care Physician:____________________Referring Physician:__________________________

GYNECOLOGICAL HISTORY

First day of last menstrual period: ____________________

Age when period began: ____________________

Length of periods (number of days you bleed): ____________________

Number of days from the start of one period until the start of the next: ____________________

Any recent changes in your period: Yes / No If yes, explain: ______________________________

Present method of birth control: ______________________________

Birth control methods tried in the past: ______________________________

Past problems with birth control: ______________________________

When was your last PAP smear: ______________________________

What were the results: NORMAL ASC-US ASC-H LSIL

Have you ever had an abnormal PAP smear: Yes / No

If yes, what were the results: ASC-US ASC-H LSIL HSIL

Has an abnormal PAP smear indicated that you were HPV positive: Yes / No

Do you do regular breast exams: Yes / No

Have you ever had a mammogram: Yes / No

OBSTETRIC HISTORY

How many times have you been pregnant: ____________________

Number of miscarriages: ____________________

Number of abortions: ____________________

Number of living children: ____________________

If currently pregnant, your LMP(Last Menstral Period) ____________________

Pregnancy	Date of Birth	Baby's Weight	Sex of Baby	Weeks Pregnant	Hours in Labor	Any complications	Type of Delivery	Hospital Name	Baby's Name
1									
2									
3									
4									
5									

IMMUNIZATIONS

Are you up-to-date on all your immunizations: Yes / No

Date of your last Tetanus shot: ____________________

PERSONAL PAST MEDICAL HISTORY (please circle and describe all that you have/have had yourself):

Alcoholism:
Anemia:
Aneurysm:
Anxiety:
Arthritis:
Asthma:
Blood Clots:
Bowel Problems:
Cancer:
Chronic Pain:
Collagen Vascular Disease (Lupus):
Dementia /Alzheimer's disease:
Depression:
Diabetes:
Eating Disorders:
Endometriosis:
Epilepsy/Seizures:
Fibroids:
Fibromyalgia:
Glaucoma:
Heart attack:
Heart disease:
Hemorrhoids:
Hepatitis:
High Blood Pressure:
High Cholesterol:
Hypoglycemia:
Hypothyroidism:
Hyperthyroidism:
Kidney infections:
Kidney stones:
Kidney failure:
Lung disease:
Meningitis:
Migraines:
Mitral Valve Prolapse:
Multiple Sclerosis:
Murmur:
Muscular Dystrophy:
Osteoporosis:
Pneumonia:
Reflux/GERD:
Stroke:
Ulcers:
Urinary Tract infections:
Environmental/Seasonal allergies:

SEXUAL TRANSMITTED DISEASES

Have you ever had an STD: Yes / No / Unsure

If yes, please circle:

Chlamydia: No / Yes
Syphilis: No / Yes
Gonorrhea: No / Yes
Trichomonas: No / Yes
Herpes: No / Yes
HIV/AIDS: No / Yes

CHILDHOOD DISEASES

Measles: No / Yes
Mumps: No / Yes
Rubella: No / Yes
Polio: No / Yes
Chicken Pox: No / Yes
Whooping Cough: No / Yes
Rheumatic Fever: No / Yes
Scarlet Fever: No / Yes

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GYNECOLOGICAL SURGERIES

Surgery	Date	Hospital	Name of Surgeon

GENERAL SURGERIES

Surgery	Date	Hospital	Name of Surgeon

ORAL SURGERIES

Have you ever had your wisdom teeth extracted: Yes / No

If yes, what year:__________________

OTHER HOSPITALIZATIONS

Reason	Date	Hospital	Physician's Notes

Name:	
Doctor's Initials:	Date:

ALLERGIES and SENSITIVITIES

Name of Medication	Allergy-describe reaction	Sensitivity-describe reaction

CURRENT MEDICATIONS Medications taken at Home

Name	Dose	Frequency	Route (oral, nasal, topical, etc)	Reason	Prescribing Doctor

**If there is insufficient space, please attach a list

OVER THE COUNTER, HERBAL PREPERATIONS, & VITAMINS

Name	Dose	Frequency	Route (oral, nasal, topical, etc)	Reason	Prescribing Doctor

**If there is insufficient space, please attach a list

PHARMACY NAME

Address: ______________________________

Phone: ____________________ Fax: ____________________

Name:	
Doctor's Initials:	Date:

FAMILY HISTORY

Mother: Living / Deceased Age of death: ______ Cause of death: ______________________________

Father: Living / Deceased Age of death: ______ Cause of death: ______________________________

Total# of Siblings: ______ # of living siblings ______ #of deceased siblings ______

Age of death: ______ Cause of death: ______________________________

Total # of Children: ______ # of living children ______ #of deceased children ______

Age of death: ______ Cause of death: ______________________________

Illnesses that someone in your family has/has had:

Illness	Relative	Paternal/Maternal	Age of Onset
Anxiety			
Blood Clots			
Breat Cancer			
Colon Cancer			
Dementia/Alzheimer's disease			
Diabetes			
Heart Attack			
High Blood Pressure			
High Cholesterol			
Mental Illness			
Osteoporosis (weak bones)			
Other cancers			
Ovarian cancer			
Stroke			
Thyroid Disease			
Uterine Cancer			

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SOCIAL HISTORY (circle the appropriate answer please)

Marital Status: Single Married Living with partner Divorced Widowed

Have you ever had sex: Yes / No

Are you currently sexually active: Yes / No

Number of sexual partners (currently): __________

Number of sexual partners (lifetime): ___________

Sexual Partners are: Men / Women / Both

Current or most recent job: ____

School completed: High school Some college College Beyond College Other

Do you exercise regularly: Yes / No If yes, how often: ___________________________

Do you wear a seatbelt: Yes / No

Current tobacco use: Yes / No If yes, amount: ___________________________

Current alcohol use: Yes / No If yes, amount: ___________________________

Do you drink caffeine on a regular basis: Yes / No If yes, amount per day: __________________________

Recreational drug use: Yes/No If yes, substance and amount: ______________________________

Regularly daily intake of Calcium or supplementation: Yes / No If yes, amount per day: ___________________________

Have you ever been sexually abused, threatened, or hurt by anyone: Yes / No

Do you have any tattoos: Yes / No If yes, give description and location: ____

____

Do you have any piercings: Yes / No If yes, give description and location: ______________________________________

____

Do you have any scars: Yes / No If yes, give description and location: ____

____

Patient Signature:____ Date:______________________________

Physician Signature:____ Date:______________________________

Name:	
Doctor's Initials:	Date: