Mt. Auburn OB-GYN Associates, Inc.

We are asking you to complete this very comprehensive form to verify all your information so that we can convert your information to an electronic medical record.

Name: _____ Date: ___/___/___ Birth Date: ___/___/___

Referred By: _____ Last 4 Digits of SS#: _____ Age: _____

Reason for visit: ☐ Routine Physical ☐ Problem Describe Problem:

_____

_____

_____

CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESS	YES	Date of Onset	MAJOR ILLNESS	YES	Date of Onset
Abnormal PAP Smear: Indicate Treatment by circling type below: **Cone Freezing LEEP Laser**			GERD / Reflux / Indigestion		
			Glaucoma		
			Heart Trouble		
Abnormal Uterine Bleeding:			Hepatitis- Type:		
Treatment: Ablation			High Blood Pressure		
Treatment: Hysterectomy			High Cholesterol		
Treatment: Medication			Kidney Infections		
Anemia / Low Blood Count			Kidney Stones		
Anxiety			Osteoporosis		
Arthritis			Polycystic Ovarian Syndrome (PCOS)		
Asthma			Rheumatic Fever		
Blood Transfusions			Stroke		
Blood Clots in Leg / Lungs			Sexually Transmitted Diseases:		
Bowel Trouble / IBS			Chlamydia		
Breast Cancer			Gonorrhea		
Colon Cancer			Herpes		
Ovarian Cancer			HIV		
Other Cancer- Type:			HPV		
Chronic Lung Disease			Thyroid Problems		
DES Exposure			Urinary Incontinence: (see below)		
Depression			Stress (Leakage when cough/sneeze)		
Diabetes Type I or Type II (circle one)			Urgency (Frequent Urination)		
Ectopic / Tubal Pregnancy			Uterine Fibroid(s)		
Endometriosis			Other: Type:		
Fracture-Type:					

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY	DATE	SURGERY	DATE
Cone Biopsy Cervix		Cesarean Section	
Bilateral Tubal Ligation		Other Surgery (Please List):	
Hysterectomy: Type: (circle one) Vaginal Abdominal Laparoscopic			
Ovaries Removed: (circle one) Both Right Left			
Diagnostic Laparoscopic			
Uterine Ablation			

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING

DRUG NAME	DOSAGE	FREQUENCY	START DATE	PHYSICIAN
List the Herbal or "Natural" remedies, over the counter drugs, and vitamins you use:				

ALLERGIES

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No If Yes, please check the list of medications below.

☐ Adhesive Tape	☐ Erythromycin	☐ Latex Gloves	☐ Phenothiazines	☐ Sulfer
☐ Barbiturates	☐ Ethiodized Oil	☐ Lidocaine	☐ Phenytoin	☐ Tetracyclines
☐ Carbamazepine	☐ Ethiadol	☐ Meperidine (Demerol)	☐ Quinolones	☐ Tuberculin Test
☐ Cephalosporins (Keflex)	☐ Glucocorticoids	☐ Morphine Sulfate	☐ Salicylates	☐ Other:
	☐ Hydrocortisone	☐ NSAIDS (Advil, Aleve, etc.)	☐ Succinimides	
☐ Codeine	☐ Insulin		☐ Sulfa	
☐ Digitalis	☐ Iodine	☐ Penicillins	☐ Sulfonylureas	

FOOD ALLERGIES SUCH AS: ☐ Eggs ☐ Milk ☐ Nuts ☐ Shellfish ☐ Soy ☐ Yams

CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	Yes	RELATIONSHIP TO BLOOD RELATIVE WITH DATE OR AGE OF ONSET
Anemia / Low Blood Count		
Anxiety		
Autoimmune Disease		
Asthma		
Blood Clots in Legs / Lungs		
Clotting Disorder		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Other Cancer- Type:		
Chronic Lung Disease		
Depression		
Diabetes		
Heart Trouble / Murmur		
High Blood Pressure		
High Cholesterol		
Osteoporosis		
Stroke		
Thyroid Disease		
Other:		

GENETIC HISTORY

Complete this section if you are of child bearing years.
Please indicate if any apply to you or your family history.

☐ Anencephalus	☐ Osteogenesis Imperfecta	☐ Spina Bifida Hydrocephalus
☐ Canavan Disease	☐ Other Specified Disorders of Metabolism	☐ Spinal Cord Anomaly, Congenital
☐ Down Syndrome	☐ Other Thalassemia	☐ Tay-Sachs Disease
☐ Fragile X Syndrome	☐ Prader-Willi Syndrome	☐ Tetralogy of Fallot
☐ Habitual Aborter	☐ Septal Closure Defect	☐ Truncus Common
☐ Hemophilia	☐ Sickle-Cell Anemia	☐ Ventricular Septal Defect
☐ Huntington's Chorea	☐ Situs Inversus	
☐ Niemann-Pick Disease	☐ Spina Bifida	☐ No Genetic History
☐ Other- Describe:		

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of Pregnancies		Full Term Births	
Premature		Abortions Induced	
Miscarriages		Living Children	
Ectopic Pregnancy / Tubal			

On the chart below, please fill in the answers for each pregnancy including abortions and miscarriages.

	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex		Del Type: Vag, Forceps, Vacuum, C-section	Anes	Early Labor?	Wt Gain	Comments / Complications	Location
1					☐ M ☐ F						
2					☐ M ☐ F						
3					☐ M ☐ F						
4					☐ M ☐ F						
5					☐ M ☐ F						
6					☐ M ☐ F						
7					☐ M ☐ F						
8					☐ M ☐ F						

SOCIAL HISTORY: Please list your life habits

Adopted / Step children in household?	☐ Yes ☐ No If Yes, how many?
Do you use a seat belt?	☐ Yes ☐ No
Do you do self breast exams?	☐ Yes ☐ No
Do you eat/drink dairy products?	☐ Yes ☐ No If Yes, how many servings a day?
Do you take calcium?	☐ Yes ☐ No If Yes, Name and Dosage:
How often do you exercise?	☐ None ☐ Less that 3 times per week ☐ More than 3 times per week
Are you sexually active?	☐ Yes ☐ No
New sexual partner < 1 year?	☐ Yes ☐ No
Number of sexual partners:	☐ Less than 5 in your lifetime ☐ More than five in your lifetime
Do you smoke or use tobacco?	☐ Yes ☐ No If Yes, how many packs per day? How many years?
Do you drink alcohol?	☐ Yes ☐ No If Yes, how many drinks per day? Drinks per week?
Do you use drugs?	☐ Yes ☐ No If Yes, what kind? How often?
Do you have a history of abuse?	☐ Yes ☐ No If Yes, ☐ Physical ☐ Emotional ☐ Sexual When?
Your type of occupation:	

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

TEST	DATE	RESULTS	IMMUNIZATIONS	DATE
Last PAP Smear			Chicken Pox Vaccine	
Bone Density – DEXA Scan			Chicken Pox Exposure	
Cholesterol			Flu Shot	
Colonoscopy/Sigmoidoscopy			Pneumococcal Vaccine	
Mammogram			TB Skin Test	
Other:			Tetanus	

Patient Questions / Comments:

Patient's Signature:_____ Date _____

Physician Comments: