Haven Ob/Gyn, LLC

HEALTH ASSESSMENT

If you are not new to this practice, please fill out only changes in your medical history.

Name Date

What is the main purpose of your visit today?

PAST MEDICAL HISTORY

Please indicate any PAST or CURRENT medical problems

Heart Disease	High Blood Pressure	Epilepsy/Seizures
Lung Disease (including Asthma)	Blood Transfusion	Breast Cancer/Biopsies
Stomach Problems	Diabetes	DES Exposure
Urinary Problems	Venereal Disease/STD	Pelvic Inflammatory Disease (PID)
Muscles/Bones Problems	Mental Illness/Depression	Tumor of Any Kind
Thyroid Disease	Blood Disease	Migreaine Headaches

Any conditions not listed?

SURGERY OR MAJOR HOSPITALIZATIONS

Reason:	Month/Year	Reason:	Month/Year

DRUG ALLERGIES	Reaction

CURRENT MEDICATIONS	Dose

In your family, do you have any of the following?

Disease:			Relationship
Heart Disease	Yes	No	
Hypertension	Yes	No	
Stroke	Yes	No	
Breast Cancer	Yes	No	
Colon Cancer	Yes	No	
Other Cancers	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Bleeding disorder	Yes	No	
Kidney disease	Yes	No	
Thyroid disease	Yes	No	
Mental Illness	Yes	No	
Others not listed	Yes	No	

Occupation:

Do you Smoke: No Yes How Much?

Do you Drink: No Occasionally Yes

Do you use illegal drugs: No Yes Type?

Marital Status: Single Married Divorced Separated

Are you exposed to any chemicals at work that may harm you or your unborn child? No Yes

Have you ever been the victim of sexual, physical, or mental abuse? No Yes Explain

PREGNANCY HISTORY

How many total pregnancies have you had? (please detail below) Largest baby?

Type: (vaginal, C-section, miscarriage/abortion)	Month/Yr	#weeks	Complications?

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HEALTH ASSESSMENT (page 2)

GYN HISTORY	PAP/MAMMOGRAM HISTORY
What was the first day of your last period?	When was your last pap smear?
How old were you when you began your periods?	Have you ever had an abnormal pap? Yes No
How often do you have periods?	If so, when and what was done about the abnormality?
How long do they last?	
Do you have any problems with your menses such	
as pain or heavy bleeding? Yes No	When was your last mammogram?
Have you ever had a sexually transmitted disease?	Was it normal? Yes No
If so, which one(s)?	

PREVENTIVE HEALTH	
Do you do the following?	
Perform a self breast exam at least once a month?	Yes No
Wear a seatbelt in the car at all times?	Yes No
Exercise at least three times weekly?	Yes No
Take a calcium supplement?	Yes No
Take a multivitamin with folate every day?	Yes No
Sunbathe frequently or go to a tanning bed?	Yes No
Eat a healthy diet?	Yes No
Get your teeth cleaned at least annually?	Yes No

REVIEW OF SYSTEMS

Do you regularly have any of the following symptoms? If so please explain in the space at the bottom.

Recurrent fevers	Persistent cough	Excessive thirst	Pain with intercourse
Persistent swollen glands	Shortness of breath	Frequent urination	Pain with menses
Skin rashes	Wheezing	Blood in your urine	Vaginal discharge or odor
Sores on the skin	Chest pain	Severe mood swings	Genital Sores
Chronic itching	Swelling of your legs	Depression	Leakage of urine
Severe headaches	Heat/cold intolerance	Anxiety	Hot flashes
Episodes of fainting	Significant weight change	Joint pain or swelling	Vaginal dryness
Seizures	Abnormal hair growth	Difficulty moving joints	
Numbness/muscle weakness	Abnormal bruising/bleeding		

Any symptoms not addressed on this questionnaire?

OTHER QUESTIONS OR COMMENTS?

We aim to provide excellent medical care at our office. This medical history is the first step in providing that care. If there is anything else you would like to tell the doctor before your visit, you may place it in the space provided below. If you do not feel comfortable writing it down, you may discuss it in private during your visit.