BILTMORE OB GYN
MEDICAL HISTORY

NAME DATE

REFERRING PHYSICIAN	ALLERGIES TO MEDICATIONS
PLEASE INDICATE REASON FOR THIS OFFICE VISIT	
	CURRENT MEDICATIONS / HORMONES / VITAMINS / HERBS
MARRIED / PARTNERED/ DIVORCED / SEPARATED / SINGLE	
OCCUPATION	**MEDICAL HISTORY**
	DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF
	THE FOLLOWING? (**CIRCLE ALL THAT APPLIES)**
GYNECOLOGICAL HISTORY	BLOOD TRANSFUSIONS
AGE PERIODS BEGAN	HEART DISEASE / MURMUR
LAST MENSTRUAL PERIOD	HIGH BLOOD PRESSURE
# DAYS PERIOD LAST	STROKE
# DAYS BETWEEN PERIODS	EPILEPSY / SEIZURES
PRESENT METHOD OF BIRTH CONTROL	MIGRAINES
LAST PAP SMEAR (DATE)________RESULT________	DEPRESSION / PSYCHOLOGICAL ILLNESS
	ASTHMA
DO YOU HAVE A HISTORY OF: (INCLUDE DATES)	PULMONARY EMBOLISM
(CIRCLE ALL THAT APPLIES)	OTHER LUNG DISEASE
ABNORMAL PAP SMEAR	PHLEBITIS / DVT
COLPOSCOPY / CRYOSURGERY / LASER SURGERY	KIDNEY STONES OR OTHER DISEASE
GENITAL WARTS / HERPES / CHLAMYDIA / GONORRHEA	THYROID DISEASE
NIGHT SWEATS / HOT FLASHES / VAGINAL DRYNESS	DIABETES
LEAKING OF URINE	HEPATITIS / LIVER DISEASE
PELVIC INFLAMMATORY DISEASE	GALLBLADDER DISEASE
INFERTILITY	ANOREXIA / BULIMIA / EATING DISORDER
ENDOMETRIOSIS	ANEMIA / BLOOD DISORDER
DES EXPOSURE	CANCER
INFREQUENT OR IRREGULAR PERIODS	COLLAGEN VASCULAR DISEASE / LUPUS
OVARIAN CYSTS	ARTHRITIS
OVARIAN CANCER	FIBROMYALGIA
UTERINE CANCER	CHRONIC FATIGUE
FIBROIDS	OSTEOPOROSIS
BREAST DISEASE	URINARY PROBLEMS
BREAST SURGERY	BOWEL PROBLEMS
BREAST D/C	GLAUCOMA
DATE OF LAST MAMMOGRAM	
MAMMOGRAM RESULT	LAST CHOLESTEROL TEST (DATE / RESULT)
	LAST FASTING BLOOD SUGAR (DATE / RESULT)
PREGNANCY HISTORY	LAST SIGMOIDOSCOPY (DATE / RESULT)
NUMBER OF ELECTIVE ABORTIONS	LAST BONE DENSITY (DATE / RESULT)
NUMBER OF MISCARRIAGES	LAST IMMUNIZATION FOR TETANUS
NUMBER OF CHILDREN	HAVE YOU BEEN IMMUNIZED FOR HEPATITIS B? YES___ NO___
NUMBER OF VAGINAL DELIVERIES	HAVE YOU BEEN IMMUNIZED FOR PNEUMOCOCCAL? YES___ NO___
NUMBER OF C SECTIONS	
COMPLICATIONS	CAFFEINE (CUPS OF COFFEE, TEA, SODA / DAY)
	CURRENT NUMBER CIGARETTES PER DAY
PAST SURGICAL HISTORY / HOSPITALIZATIONS	PAST CIGARETTE USE (# OF YEARS)
YEAR(S), PROCEDURES(S)	CURRENT AND PAST ALCOHOL INTAKE
	STREET DRUG USE? YES___ NO___
FAMILY HISTORY	EXERCISE? YES NO
BREAST CANCER STROKE	EXERCISE (FREQUENCY)
OVARIAN CANCER HIGH CHOLESTEROL	EXERCISE (DURATOIN)
UTERINE CANCER OSTEOPOROSIS	DO YOU PERFORM SELF BREAST EXAMS? (YES / NO)
COLON CANCER BLOOD CLOTS	SUN EXPOSURE?
DIABETES ALZHEIMERS	SPF #
HIGH BLOOD PRESSURE THYROID DISEASE	
HEART ATTACK / HEART DISEASE OTHER	
PATIENT NAME	**CHART # DOB**

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