PREMIER OBGYN NAPA INC.
Patient History Form:

Patient
Name:____________________ Date___/___/___
SS #:__________/____/_________ Date of birth_______

PAST MEDICAL HISTORY:
Primary Care Doctor's Name_______________________
Last exam there: (date)___________________________
Does your Primary Care Physician send you for Bloodwork, Xrays, Bone Density scans and other testing?
______________ If so, which lab(s) do you use?
____
Have you ever been hospitalized?___________________
If so, what for?
____
____
Have you been vaccinated for Hepatitis B?______
Hepatitis A?___________ Been tested for any type of Hepatitis?______________ Which type?__________
Results?_________________________
Have you been screened for Tuberculosis? ( ) Y ( ) N
If so, what were the results?_________________
Have you ever had or been treated for a sexually transmitted disease?___________________If so, which one(s)? ( ) chlamydia ( ) gonorrhea ( ) HPV
( ) Syphilis ( ) HIV ( ) other_______________

Have you or are you currently being treated for any of the following?:
( ) Heart disease/murmur/chest pain ( ) Diabetes
( ) High Cholesterol ( ) Hypertension (high blood pressure) ( ) Heartburn/GERD/Acid reflux/Ulcer
( ) Asthma ( ) Cancer What type(s)______________
( ) Anemia or blood problems--what type_____________
( ) Lung problems/cough/shortness of breath
( ) Thyroid problems---hyper or hypo active___________
( ) Neurologic Problems- What type___________________
( ) Stroke/blood clots/ bleeding in the brain ( ) Kidney problems or bladder problems-What type_______________
( ) Psychiatric problems: Depression/anxiety/BiPolar disorder/ADHD, or others: What type____
____

PLEASE DESCRIBE ANYTHING FROM THE ABOVE LIST, OR ANYTHING NOT ON THE ABOVE LIST THAT REQUIRES AN EXPLANATION OF YOUR MEDICAL HISTORY:____
____
____

Please list any past surgeries: (with dates)

DATE	TYPE OF SURGERY	WHERE?

Do you have any ALLERGIES to any medications? If so what?

____

____

_______________ **What type of reaction do you have?**

____

Please list your medications, with Doses.______________________________________

____

____

____

OBSTETRICAL HISTORY:
Please list every pregnancy, in order

DATE	TYPE (vaginal or c section)	Complication ?	Boy/Girl/ weight	Where?

Any pregnancies that did not result in the birth of a baby?

(   ) Miscarriages   #___________
Complications__________________________________
(   ) Terminations of pregnancy (voluntary, or for medical reasons)   #________________ Complications__________

FAMILY HISTORY:

FAMILY MEMBER	LIVING?	AGE (or age at death)	Serious illnesses
MOTHER			
FATHER			
SISTER #( )			
BROTHER # ( )			
ANY OTHERS WITH ILLNESS: WHO?			

Has any family member had:

(   ) Breast Cancer---who? Age at diagnosis________
Outcome--Still living?____________Age at death_______

(   ) Ovarian Cancer---who?   Age at diagnosis_______
Outcome---Still living?____________Age at death

(   ) Mental Illness/
depression____
____________________________who?
___________________________________Diagnosis?
____Outcome?
____

GYNECOLOGICAL HISTORY:

Have you ever had an abnormal Pap smear?(   )Y(   ) N

When, what type of abnormality, and what type of treatment did you have for it?

____
____

When was your last Pap smear? ______________________________ Result? _______________________________________

Have you ever had a mammogram? _________________________________ Result? _________________ Last mammogram Date______________________

Have you ever been treated for any gynecological conditions?
____
____

Have you ever used any form of birth control?
____
____
____

BY SIGNING BELOW, I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE ALL INFORMATION I HAVE FURNISHED HERE IS COMPLETE, TRUE and ACCURATE.

Patient/Legal Guardian Signature__________________________________
Date:______/_______/________