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Obstetrics and Gynecology
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MEDICAL HISTORY INFORMATION

Name: Last _____First _____Initial____Age: _____Race:_____
Height_____ Weight_____Any recent change in weight? _____
Last Menstrual Period:_____ Last Pap smear taken:_____
Have you been treated by a physician in the last two years?_____ When and for what?_____
Physician's Name:_____
Have you ever had any serious illness? _____What and When?_____
Have you ever had a Mammogram?_____ When?_____
Have you ever had any surgery or general anesthesia (put to sleep)?_____
When and for what?_____
Have you been taking any medication during the past year? _____Name and dosage_____
_____
Are you taking birth control pills?_____ Brand and dose?_____
Are you allergic to any medication?_____ What?_____
Any previous exposure to Penicillin?_____
Do you have A Living Will?_____

Family History:
On the line after listed condition, write "0" for no history. Write "M" for mother. Write "F" for father
High Blood Pressure_____Twins_____Diabetes_____Heart Disease_____
Cancer of: Breast _____ Ovaries_____Colon_____

Obstetrical History:
Are you pregnant now?_____

Total Pregnancies_____Full Term_____Premature_____Twins_____
C-section_____Abortion_____Miscarriages_____

Year of Birth	Place of Birth	Sex	Name	Weight	Type of Delivery

Total Living children today _____Patient Vaccines in last 10 years_____

Allergies to local anesthetics……Y……N
Bleeding Tendency……Y……N
Cancer……Y……N
Cosmetic Surgery……Y……N
Epilepsy or Seizures……Y……N
Heart Disease……Y……N
Hepatitis or Jaundice ……Y……N
Kidney Disease ……Y……N
Lung Disease……Y……N
Orthopedic Implants ……Y……N
Rheumatic Fever……Y……N
Stroke……Y……N
Urinary Incontinence or leakage……Y……N
Smoke or Use of Tobacco ……Y……N

Anemia……Y……N
Blood Transfusion History……Y……N
Breast Disease or Surgery……Y……N
Chest pain ……Y……N
Diabetes……Y……N
Heart Attack……Y……N
Heart Valve Problem/Replscement……Y……N
High Blood Pressure……Y……N
Excessive Alcohol Use……Y……N
Illegal Drug Use……Y……N
Liver Disease……Y……N
Murmur……Y……N
Polio……Y……N
Sexually Transmitted Disease……Y……N
Ulcers……Y……N

Why are you seeing the doctor today?

_____
_____

I certify that the above information is accurate to the best of my know ledge and Hereby authorize any medical information to be released to San Martin OB/GYN

Signature of Patient or Guardian ⊗ _____Date:_____