

PATIENT HISTORY

...For the best care possible, please complete this form as accurately as possible...

Name _____ Date _____

Height _____ Weight _____ Level of Nervousness: NOT NERVOUS 1 2 3 4 5 6 7 8 9 10 EXTREMELY NERVOUS
(circle a number)

Medical History

Do you consider yourself in good health? Yes No

What medical problems do you have? _____

Have you ever been hospitalized? Yes No

For what reason? _____

Are you currently taking medication? Yes No

Type and reason: _____

Do you use tobacco? Yes No

Do you use street drugs? Yes No

Type and last time taken _____

Do you take antibiotics before dental work? Yes No

When was the last time? _____

Any prior abdominal/pelvic surgeries? (e.g. c-sections) Yes No

When and why? _____

Date of your last pap smear _____

Where? _____

Ever had an **abnormal** pap? Yes No When? _____

Are you allergic to: (Please write YES or NO on each line)

_____ Local anesthetics (novacaine, lidocaine, etc.)

_____ Doxycycline (related to tetracycline)

_____ Metronidazole or Flagyl

_____ Ibuprofen, Advil, Aleve, Motrin

_____ Iodine

Any other drug allergies? _____

Have you ever had: (Please write YES or NO on each line)

_____ Heart disease, rheumatic fever, heart murmur

_____ Anemia

_____ **Excessive bleeding (post-partum or post ab)**

_____ Dizziness, fainting spells, epilepsy

_____ **Asthma** (do you have your inhaler with you?) _____

_____ Infection of the uterus or tubes, gonorrhea, PID

_____ Other Sexually Transmitted Disease _____

Number of previous

Vaginal births _____

C/sections _____

Tubal Pregnancies _____

Abortions _____

Miscarriages _____

Date the last pregnancy ended _____

Are you currently breast feeding? Yes No

Have you had any of the following tests for this pregnancy?

Urine/ Blood Yes No Results: _____

Ultrasound Yes No Results: _____

What pregnancy symptoms are you experiencing?

Pain (explain) Nausea Breast Tenderness

Clothes snug Tiredness Other _____

Are you currently bleeding? Yes No

If you know it, please write your **blood type** _____

What was the first day of your last menstrual period?

Was that period normal? Yes No

Are your periods usually? Regular Irregular

How many days per cycle? _____

Any complications with prior abortions? Yes No

If yes, circle all that apply: infection/ bleeding/ cramping/

procedure repeated/ hospitalized/ transfusion

Please check which methods of birth control you were using when

you became pregnant:

Pills Depo-Provera Nuva Ring

Condoms Patch Spermicide

IUD Sterilization Diaphragm

Withdrawal Rhythm None

Other _____

Would you like a new method at this time? Yes No

Name of person here with you today: _____ Relationship: _____

Do you allow us to give this person information regarding this appointment Yes No

Patient Signature: _____ **Date:** _____