Mt. Pleasant Ob/Gyn **3510 Highway 17 North, Suite #225 Mt. Pleasant, SC2 9466**

Name: ______________________ Date: ______________________

Birthdate: ______________________

Reason for Visit: ______________________

Medical History: (X if positive)

____ Diabetes
____ Kidney Disease
____ Bladder Infections
____ High Blood Pressure
____ Heart Disease
____ Heart Murmur
____ Rheumatic Fever
____ Gallbladder Disease
____ Liver Disease
____ Hepatitis
____ Jaundice
____ Anemia
____ Blood Problems
____ Sickle Cell Disease
____ Problems with Anesthesia
____ Other: ______________________

____ Epilepsy/Seizures
____ Severe Headache
____ Emotional Problems
____ Thyroid Problems
____ Goiter
____ Asthma
____ Glaucoma
____ Birth Defects
____ Pneumonia
____ Tuberculosis
____ Arthritis
____ Muscle Problems
____ Bone Problems
____ Nerve Problems
____ Exposure to Toxic Chemicals/Radiation

Family History: (X if positive)

____ Cancer of the breast
____ Cancer of female organs
____ Other cancer
____ Diabetes
____ High Blood Pressure
____ Kidney Disease
____ Other: ______________________

____ Tuberculosis
____ Blood Disorders
____ Bleeding Disorders
____ Genetic Diseases
____ Birth Defects
____ Heart Diseases

Habits:

____ Alcohol (amt) ______________________
____ Other: ______________________

____ Cigarettes (amt) ______________________

Hospitalizations and Operations: (Do not include obstetrical deliveries)

Date	Operation and/or Reason for Hospitalization	Findings/Complications

Current Medications:

Start Date	Drug Name/Dose/Reason

Allergies:

Drug/Reaction

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Gynecologic Problems: (X if positive)

_____ Bleeding Problems
- _____ No menses or infrequent
- _____ Irregular menses
- _____ Heavy menses
- _____ Abnormal bleeding/spotting

_____ Pain
- _____ Painful urination
- _____ Painful intercourse
- _____ Abdominal pain
- _____ Pelvic pain

_____ Breast Problems
- _____ Painful breasts
- _____ Breast lump
- _____ Nipple discharge
- _____ Breast cysts or tumors

_____ Other ______________________

_____ Vaginal Discharge, odor, irritation
_____ Sexual problems
_____ Mother took DES
_____ Abnormal pap smear
_____ LEEP or cryotherapy (freezing)
_____ Gonorrhea, syphilis, chlamydia
_____ Herpes
_____ Genital warts
_____ Severe pelvic infection
_____ Pelvic cysts or tumors
_____ Frequent bladder infections
_____ Rectal bleeding
_____ Severe constipation
_____ Chronic diarrhea
_____ Surgery on female organs
_____ Tubal ligation

Date of last mammogram: ______________ Date of last pap: ______________

Menstrual History:

First day of last period: ______________
Age at first period: ______________
Periods generally come every ________ days
Periods generally last ________ days
Menstrual flow is light/moderate/heavy (circle one)

Pregnancy History:

_____ # times pregnant
_____ # full term births
_____ # premature births
_____ # miscarriages
_____ # abortions
_____ # living children

Delivery Record:

Date	Weight	Gender	Length of Pregnancy	Type of delivery (vag, c-section, forceps, vacuum)	Complications (maternal/fetal)

Contraception:

Method	Brand Name	Date of Usage	Reason for Discontinuing
Birth control pills			
IUD			
Condoms			
Other			