Clear Form

OB/GYN Associates of the Merrimack Valley
A CIRCLE HEALTH MEMBER
Complete connected care℠

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

SURGICAL HISTORY (Not Ob/Gyn related): *Please list all prior surgeries and dates.*

Surgery	Date

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusions
- ☐ Bronchitis
- ☐ Chlamydia
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Herpes - genital
- ☐ High blood pressure
- ☐ HIV+
- ☐ Kidney and/or liver disease
- ☐ Pelvic inflammatory disease
- ☐ Thyroid disease
- ☐ Vaginal Infections
- ☐ Venereal Warts
- ☐ Other: _____

MENSTRUAL HISTORY: *Complete even if post-menopausal or no longer having periods.*

Age of first menses: _____
Duration of bleeding: _____ days
Does bleeding or spotting occur between periods? □ Yes □ No
Does bleeding or spotting occur during intercourse? □ Yes □ No
Menses start every ____ days
Date of last menstrual period _____
Is pain associated with periods? □ Yes □ No
If yes is it before menses, during or after menses? _____

PAP SMEAR/MAMMOGRAM HISTORY:

Date of last pap smear: _____
Have you ever had an abnormal pap?
□ Yes □ No When:_____
If yes, what type of treatment: _____
Date of last mammogram: _____
Have you ever had an abnormal mammogram?
□ Yes □ No When: _____

PAST OBSTETRICAL/GYNECOLOGICAL SURGICAL HISTORY: *Please indicate whether you have had any of the following surgeries and the date.*

- ☐ Cesarean section, _____
- ☐ Dilatation & Curettage, _____
- ☐ Abdominal hysterectomy, _____
- ☐ Vaginal hysterectomy, _____
- ☐ Hysteroscopy, _____
- ☐ Infertility surgery, _____
- ☐ Laparoscopy, _____
- ☐ Myomectomy, _____
- ☐ Tuboplasty, _____
- ☐ Tubal ligation, _____
- ☐ Vaginal/bladder repair for prolapse or incontinence, _____
- ☐ Ovarian cyst removal, _____
  specify left or right ovary, _____
- ☐ Removal of ovary, _____
  specify left of right ovary, _____
- ☐ Other: _____

PREGNANCY HISTORY: *Please list all pregnancies.*

						CHILD		
Year	Place of delivery or abortion	Duration of pregnancy	Hours of labor	Type of delivery	Complications to mother and/or infant	Sex	Birth weight	Present health

PRENATAL HISTORY: *Please complete only if you are pregnant or planning to become pregnant in the near future.*

Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?

- ☐ Down Syndrome
- ☐ Chromosome abnormality
- ☐ Neural tube defects
- ☐ Hemophilia
- ☐ Muscular Dystrophy
- ☐ Connective tissue disease
- ☐ Neurological disorders
- ☐ Birth defects
- ☐ Mental retardation
- ☐ Tay Sachs disease
- ☐ Thalassemia/Anemias
- ☐ Sickle Cell disease
- ☐ Cystic Fibrosis
- ☐ PKU
- ☐ Congenital heart defects
- ☐ Other: _____

Have you ever been diagnosed with the following?

- ☐ Pre-eclampsia
- ☐ Chronic hypertension
- ☐ Type 1 or 2 diabetes
- ☐ Renal (kidney) disease
- ☐ Auto immune disease (Lupus, Crohn's, etc)

Since your last period have you had any of the following?

- ☐ Medications
- ☐ Recreational Drugs
- ☐ Diagnostic imaging
- ☐ Alcohol

Have you traveled outside of the US in the past year? ☐ Yes ☐ No
Have you or the baby's father had a stillborn child or three or more pregnancy loses? ☐ Yes ☐ No
If yes, have either of you had chromosomal studies? ☐ Yes ☐ No
Have you ever had anesthesia? ☐ Yes ☐ No
Any reactions to anesthesia? ☐ Yes ☐ No

Will you be 35 years of age or older when the baby is born? ☐ Yes ☐ No
Are you or the baby's father of Jewish, French-Canadian, African-American, or Mediterranean background? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No
Are blood transfusions acceptable to patient? ☐ Yes ☐ No
What is your average daily intake of caffeine? _____

SOCIAL HISTORY: *Please complete the below sections for all new patients.*

Exercise:
Do you exercise regularly? ☐ Yes ☐ No

Tobacco Use:
☐ Current ☐ Never ☐ Former: Quit on: _____
If current, # of packs/day ___ # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ No ☐ Yes

Drug Use:
Do you use any recreational drugs? ☐ Yes ☐ No
If yes please list _____
If you have used in the past, how long have you been drug free? _____
Have you ever used needles for IV drug use? ☐ Yes ☐ No

Alcohol Use
Do you drink alcohol? ☐ Yes ☐ No
If yes, # of drinks per week: _____
What type of alcohol: _____
Is alcohol a concern for you or others who surround themselves around you? ☐ Yes ☐ No

SAFETY
Do you wear a seatbelt regularly? ☐ Yes ☐ No
Do you wear a bike helmet regularly? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Do you feel safe in your current relationship? ☐ Yes ☐ No

Have you ever been physically or sexually abused? ☐ Yes ☐ No
Do you have a gun in your home? ☐ Yes ☐ No
Are you a member of a gang? ☐ Yes ☐ No
Other concerns: _____

SOCIOECONOMICS
Occupation:_____
Degree of education completed:_____
Marital status: _____
Spouse/partner's name: _____
Who lives at home with you? _____

SEXUALITY
Are you sexually active? ☐ Yes ☐ No
Current sex partner(s) are: ☐ male ☐ female
If sexually active do you practice safe sex? ☐ Yes ☐ No

Birth control method: _____
Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
If yes please include: _____

Are you interested in being screened for sexually transmitted disease? ☐ Yes ☐ No
Other Concerns: _____

OTHER SYMPTOMS: *Please complete if you have experienced any of these symptoms recently::*

- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in energy
- ☐ Change in exercise tolerance
- ☐ Hair growth
- ☐ Hair loss
- ☐ Change in urination function
- ☐ Hot flashes/flushing
- ☐ Breast discharge
- ☐ Other: _____

FAMILY HISTORY: *Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle
Living Status										
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease High	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT (blood clot)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fibroids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐