

OB HISTORY: Tell us about your pregnancies.

Never Pregnant Number of Pregnancies _____ Number of Deliveries _____

Date	Outcome: <i>Please circle</i>	Delivery type: <i>please circle</i>
	Full term / Preterm / Stillbirth / Miscarriage / Termination / Ectopic	Vaginal / C-section
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FAMILY HISTORY: Please circle any of the following that affect a family member, indicate relationship (i.e. Mother, Father, Brother, Sister, Grandparent, Aunt, Uncle) and if they are maternal or paternal.

Disease	Family Member
Breast cancer	
Uterine cancer	
Colon/Rectal cancer	
Ovarian cancer	
Prostate cancer	
Has anyone in the family had genetic testing?	
Heart disease	
High blood pressure	
Stroke	
Thyroid disease	
Diabetes	
Osteoporosis	
Bleeding/Coagulation disorder	
Other	

CANCER (List Type)

- _____
- _____
- _____

HEART DISEASE

- High Blood Pressure
- High Cholesterol
- Heart Attack
- Cardiomyopathy
- Murmur
- Pacemaker/Defibrillator

DERMATOLOGY

- Eczema
- Rosacea
- Vitiligo

ENT

- Meniere's Disease
- Tinnitus
- Hearing Loss
- Sleep Apnea

ENDOCRINE

- Diabetes
- Osteopenia
- Osteoporosis
- Thyroid Problems

GI

- Colon Polyps
- Irritable Bowel Syndrome
- Acid Reflux

GYNECOLOGY

- Dysplasia
- Endometriosis
- Fibroids
- Infertility
- PCOS

HEMATOLOGY

- Von Willebrand Disease
- Factor V Leiden
- Coagulation Disorder
- DVT/Pulmonary Embolism
- Sickle Cell Disease/Trait

INFECTIOUS DISEASE

- HIV
- Hepatitis
- Herpes
- HPV
- MRSA Infection

NEUROLOGIC

- Migraine
- Mental Retardation
- Autism
- Multiple Sclerosis
- Parkinson's
- Neuropathy
- Seizures

ORTHOPEDIC

- Osteoarthritis

PSYCHIATRIC

- ADD
- Anxiety
- Depression
- Insomnia
- Bipolar Disorder
- OCD
- PMS

PULMONARY

- Asthma
- Seasonal Allergies
- Pulmonary Fibrosis
- Emphysema
- COPD

RHEUMATOLOGY

- Fibromyalgia
- Lupus
- Gout
- Raynaud's Disease
- Sjogren Syndrome
- Scleroderma
- Chronic Fatigue Syndrome
- Psoriasis
- Rheumatoid Arthritis

UROLOGY

- Kidney Stones
- Interstitial Cystitis
- Over Active Bladder

OTHER

- _____
- _____
- _____
- _____
- _____

REVIEW OF SYSTEMS: Please circle any problems that you are currently experiencing

CONSTITUTIONAL: fatigue, weight gain, weight loss

LUNGS: cough, wheezing, shortness of breath

CARDIOVASCULAR: chest pain, palpitations, swelling of extremities

BREAST: mass, tenderness, skin changes, nipple discharge

GASTROINTESTINAL: abdominal pain, nausea, vomiting, constipation, bloating, diarrhea, change in bowel movements, rectal bleeding

GENITOURINARY: urinary urgency, urinary frequency (urinating more than 8 times a day), pain with urination, pelvic pain, blood in urine, getting up at night to urinate, leaking urine, vaginal discharge, vaginal odor, vaginal itching, vaginal burning, vaginal irritation, lesions, bleeding (if you are menopausal)

ENDOCRINE: change in appetite, cold intolerance, heat intolerance

MENSTRUAL: irregular periods, PMS symptoms, heavy periods, painful periods

MENOPAUSAL: hot flashes, night sweats, vaginal dryness

SEXUAL: bleeding after intercourse, decreased sex drive, painful intercourse

NEUROLOGICAL: headache, dizziness, memory loss, problems concentrating

HEMATOLOGIC: swollen glands

SKIN: rash, abnormal moles, hair loss

PSYCHIATRIC: depression, anxiety, sleep disturbances