NAME: _____ BIRTH DATE: ____ / ____ / ____ DATE: ____ / ____ / ____

AGE: HT: BP: WT:

REASON FOR VISIT:

Last menstrual period:		Last Mammogram: / /	
Last pap smear: / /		Hx: std:	Yes / No
Hx abn pap:	Yes / No	Hysterectomy:	Yes / No

OB/GYN HISTORY

FIRST MENSES, AGE:: _____ FREQUENCY: _____ DAYS: _____ GRAVIDA _____ PARA _____

	Number		Number
Births		Abortions	
Miscarriages		Living children	

PAST PREGNANCIES (LAST SIX)

MONTH DAY YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

DRUG ALLERGIES: _____

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES/ILLNESSES

Type	Date	Type	Date

FAMILY HISTORY

FAMILY LIVING: MOTHER ☐ FATHER ☐ BROTHER ☐ SISTER ☐

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

SOCIAL HISTORY

Habits						
Smoking	No	☐	Yes	☐	Packs per day	Years
Alcohol	No	☐	Yes	☐	Drinks per day	Drinks per weeks
Drug Use	No	☐	Yes	☐		

Signature of patient: _____

Pharmacy phone # _____