

**OB/GYN SPECIALISTS OF NORTHERN KENTUCKY
MEDICAL HISTORY**

Patient Name: _____ Date: _____

Reason for Visit: _____ Date of Birth: _____

Date of last menstrual period: _____ How many days do you flow? _____

Is your bleeding excessive? Yes _____ No _____

What type of contraception are you currently using? _____

Date of last Pap smear: _____ Was it normal? Yes ___ No ___

Date of your last mammogram: _____ Was it normal? Yes ___ No ___

Please indicate how many you have had: Miscarriages: _____ Stillborn: _____
Abortions: _____ Living Children: _____

Any problems with the following? If problem now, write "Current"

Head	N ___ Y ___ AGE ___	Kidney/Bladder	N ___ Y ___ AGE ___
Ear/Nose/Throat	N ___ Y ___ AGE ___	Blood Clots	N ___ Y ___ AGE ___
Eyes	N ___ Y ___ AGE ___	Stomach	N ___ Y ___ AGE ___
Thyroid	N ___ Y ___ AGE ___	Intestines/Colon	N ___ Y ___ AGE ___
Lungs	N ___ Y ___ AGE ___	Hemorrhoids	N ___ Y ___ AGE ___
Heart	N ___ Y ___ AGE ___	Hernia	N ___ Y ___ AGE ___
Diabetes	N ___ Y ___ AGE ___	Cancer	N ___ Y ___ AGE ___
High Bld Pressure	N ___ Y ___ AGE ___	Breasts	N ___ Y ___ AGE ___
Yellow Jaundice	N ___ Y ___ AGE ___	Bleed between periods	N ___ Y ___ AGE ___
Irregular Periods	N ___ Y ___ AGE ___	Painful Menstruation	N ___ Y ___ AGE ___

INFECTION HISTORY: Have you ever been exposed to or are you at risk for:

HIV/AIDS: Yes ___ No ___ Toxoplasmosis: Yes ___ No ___ Tuberculosis: Yes ___ No ___
Hepatitis B or A: Yes ___ No ___ Herpes: Yes ___ No ___ Gonorrhea: Yes ___ No ___
Chlamydia/Syphilis: Yes ___ No ___ Human Papilloma Virus (HPV): Yes ___ No ___
Other: _____

PAST SURGICAL HISTORY: Have you had these surgeries:

Appendectomy	_____ Date _____	C-Sections	_____ Date _____
Gallbladder	_____ Date _____	Hysterectomy	_____ Date _____
Tubal Ligation	_____ Date _____	Other:	_____

List any allergies to medications: _____

Are you allergic to Latex? Yes ___ No ___

List Current medications: _____

Pharmacy Name: _____ Phone Number: _____

Location Address: _____

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FAMILY HISTORY

Do any members of your family (father, mother, sisters, brothers) have or had?

Diabetes	Yes ___ No ___	Which member _____
High Blood Pressure	Yes ___ No ___	Which member _____
Heart Disease	Yes ___ No ___	Which member _____
Breast Cancer	Yes ___ No ___	Which member _____
Ovarian Cancer	Yes ___ No ___	Which member _____
Cancer-other	Yes ___ No ___	Which member _____
Tuberculosis	Yes ___ No ___	Which member _____

Is your mother living? _____ Age _____ In good health? _____
If deceased, age at death _____ Cause of death _____

Is your father living? _____ Age _____ In good health? _____
If deceased, age at death _____ Cause of death _____

Number of sisters _____ and/or brothers _____

Do you consider yourself: heterosexual ___ homosexual ___ bisexual ___

Do you smoke? Yes ___ No ___ 1/2 pack/day ___ 1 pack/day ___ 1+ pack/day ___

Do you drink alcohol? Yes ___ No ___ socially ___ moderately ___ heavily ___

Have you had a bone density scan (DexaScan) in the last 2 years? Yes ___ No ___

Do you suffer from urinary leakage? Yes ___ No ___

In your job are you exposed to: fumes ___ chemicals ___ extreme heat ___ other hazards ___

Are you interested in any of the following cosmetic laser services?

Hair removal	Yes ___ No ___
Wrinkle/stretch mark reduction	Yes ___ No ___
Skin tightening/cellulite reduction	Yes ___ No ___
Scar reduction	Yes ___ No ___
Spider vein treatment	Yes ___ No ___
Leg vein treatment	Yes ___ No ___
Skin spot removal	Yes ___ No ___
Sun spot/age spot/freckle removal	Yes ___ No ___

Signature _____ Date _____

05/08