EAST LAKELAND
OB/GYN ASSOCIATES, PA

HEALTHCARE FOR WOMEN BY WOMEN

NEW PATIENT MEDICAL HISTORY FORM

NAME: ____ DATE OF BIRTH: ________________________

EMAIL ADDRESS: ____(required for access to your chart)

MEDICATION LIST: (*include all prescription and non-prescription medications currently taking or have taken in last week)*

Include Name of Medicine, strength/dosage, and frequency or how often you take it (if more space is needed please bring list with you)

____ ____
____ ____
____ ____
____ ____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ________NO ________ YES (If yes, please list below and indicate reaction that occurred)

____ ____
____ ____

NAME OF PHARMACY AND LOCATION: ____

All prescriptions will be sent electronically to your pharmacy unless indicated by your doctor at the time of your visit.

REASON FOR VISIT: (please check one) _____Annual / Wellness Exam _____Gynecological visit / Problem _____Pregnancy Confirmation

_____ Referral by Dr. ____ Other: _________________________________

PROCEDURE HISTORY:

Date of Last Pap Smear: _______________ Mammogram: ________________ Colonoscopy: _______________ Bone Density:_______________

MENSTRUAL HISTORY: (*Please fill in the blanks and circle yes or no where indicated)*

Age when Menstruation started: __________ Date of Last Menstrual period: _________________ Did you have a period last month? YES / NO

Are your periods regular? YES / NO How often do you menstruate? Every _______days. How long do your periods last? ____________days

Number of pads or tampons soaked in 24 hours on the heaviest day of bleeding? _________

Cramps are _____Mild _____Moderate _____Severe ____No pain

Do you have spotting between your periods? YES / NO Do you have bleeding or spotting after intercourse? YES / NO Do you douche? YES / NO

CONTRACEPTION: (*Please check all that apply)*

______ None _____ Attempting Pregnancy _____Birth Control Pills _____ IUD: (year inserted) ______________
______ Natural Family Planning _____Condoms _____Contraceptive Ring _____ Contraceptive Implant: ______________
______ Menopause _____ Hysterectomy _____Tubal Ligation _____ Vasectomy
______ Essure

Are you needing birth Control today? YES / NO Do you have a preference? ____

PAST GYNECOLOGIC HISTORY: (*Please check all that apply)*

Abnormal Uterine bleeding _____ Abnormal Pap Smear_____ Human Papilloma Virus (HPV)______ Uterine Fibroids_______

Endometriosis_____ Vaginitis_____ Fibrocystic Breast_____ Breast Cancer: _______

Sexually Transmitted Disease: Gonorrhea___ Chlamydia___ Herpes____ Syphilis____ HIV____ Trichomonas____ Other: ______________________

Comments: ____

SOCIAL HISTORY:

Single _____ Married _____ Separated_____ Divorced_____ Widowed_____

Tobacco Use:
___ Never a smoker
___Former smoker
___Current every day smoker
___Current someday
Per day_________(pks/cig)

Alcohol Use: YES / NO
___Daily # glasses_____
___Weekly:__________
___Monthly:_________

Drug Use: YES / NO
___Current use: ____________
___Currently in Rehab
___Former use

Sexually activity:
History of sexual activity: YES / NO
Currently sexually active: YES / NO
# of partners in last year_____
# of partners in lifetime _____

PREGNANCY HISTORY:

Total # Pregnancies _______Term Deliveries _____ Preterm Deliveries _____ Miscarriages _____ Abortions _____ Ectopic _____ Living Children_____

(Please complete the chart below concerning all pregnancies regardless of outcome. If you have had more than 5 pregnancies, list the remaining pregnancies on the back)

Date of Delivery, Termination or loss	**# Weeks**	**Delivery Type** *(Vag, C/S, VBAC, Miscarriage, Abort)*	**Spontaneous Or Induction**	**Gender M / F**	**Weight**	**Anesthesia** None / Epid /Spinal	**PROBLEMS** *(Indicate reason for C/S If Done)*

Mark any previous problems related to pregnancies:

_____ Essential Hypertension _____Preeclampsia _____ Diabetes _____ Gestational Diabetes
_____ Preterm Labor _____ Preterm Delivery _____ Incompetent Cervix _____ Excessive vomiting
Other / Comments:____

Genetic History: (Check all that apply and indicate which family member)

X	**Condition**	**Relationship**	**X**	**Condition**	**Relationship**	**X**	**Condition**	**Relationship**
	Down Syndrome (Trisomy 21)			Sickle Cell Disease or Trait			Muscular Dystrophy	
	Neural Tube Defects			Thalassemia			Other Birth Defects	
	Congenital Heart Defects			Tay-Sachs			Other Genetic disorders	
	Hemophilia			Autism			Recurrent Pregnancy loss	
	Cystic Fibrosis			Mental Retardation				
	Huntington's Chorea			Canavan Syndrome			NO KNOWN HISTORY	

If you are currently pregnant, have you traveled outside the United States or been in contact with anyone having the Zika virus since your last menstrual cycle? YES / NO

FAMILY HISTORY: (Please indicate relationship of family member and whether paternal or maternal grandparent when applies)

High Blood Pressure____
Diabetes ____
Heart Disease____
Thyroid Disorder____
Breast Cancer: ____
Ovarian Cancer ____
Intestinal Cancer____
Blood Clotting Disorder____
Other: ____

SURGICAL HISTORY: (Please indicate year or age when surgery occurred)

Biopsy of Cervix_____________________
LEEP____________________________
Cryo (freezing of Cervix)_______________
Cone Biopsy of Cervix_________________
Dilation and Curettage (D&C)___________
Elective Abortion_____________________
Tubal Ligation________________________
Abdominal Hysterectomy__________________
Laparoscopic Hysterectomy________________
Vaginal Hysterectomy____________________
C-Section_____________________________
Cerclage______________________________
Essure_______________________________
Breast Biopsy__________________________
Gallbladder Removal________________
Appendectomy____________________
Hysteroscopy_____________________
Laparoscopy______________________
Endometrial Ablation_______________
Ovaries Removed__________________
Mastectomy______________________
Other: ____

NO SURGERIES __________ (initials)

MEDICAL HISTORY: (Please check all conditions you have been treated for both past and present)

System	X	Condition	X	Condition	X	Condition	X	Condition		
Cardiac:		Heart Disease		Heart Failure		High Blood Pressure		High Cholesterol		Other:
Endocrine		Diabetes		Hyperthyroid		Hypothyroid		Obesity		Other:
Respiratory		Allergy		Asthma		Emphysema				Other
Gastrointestinal		Acid Reflux		Irritable Bowel		Colon Cancer				Other:
Urinary		Urinary Tract Infection		Kidney disorder		Kidney Stones				Other
Muscular/ Skeletal		Osteoarthritis		Low Back pain		Osteoporosis		Fibromyalgia		Other
Neurological		Headaches		Brain tumor		Seizures		Epilepsy		Other
Psychiatric		Anxiety		Depression		PMS		Bipolar Disorder		Other

Other conditions not indicated above: ____

CURRENT COMPLAINTS: (Please check all that apply and give brief explanation)
REVIEW OF SYSTEMS: (Please circle all that apply and give brief explanation if needed)

Systemic	None	Weight Change	Fever	Night sweats	Fatigue
Sinus	None	Sinus Pain	Congestion		
Head	None	Headache	Eyes	Ears	Throat/Neck pain
Breast	None	Breast Pain	Nipple Discharge	Breast lump	
Chest	None	Heart	Lungs	Cough	
GI	None	Nausea	Vomiting	Abdominal Pain	
Genital Urinary	None	Pain with urination	Loss of urinary control	Blood in urine	Genital lesion/sore
Skin	None	Skin rash	Mole	Sores	
Musculoskeletal	None	Bone or joint pain	Muscle aches		
Endocrine	None	Excessive sweating	Excessive thirst	Change in sex drive	
Psychological	None	Sleep changes	Anxiety	Depression	
Neurological	None	Dizziness	Seizures	Fainting	
Other					

Other complaints not listed above or comments concerning complaints:
____
____
____

Please list any other doctors currently treating you. This information is needed for Continuity of Care: (Name and phone number)

____
____

PLEASE REVIEW FORM AND INFORMATION FOR ACCURACY AND COMPLETE ALL AREAS SO WE MAY BETTER SERVE YOU.

PAP SMEARS

Your screening Pap smear could require a pathologist's review. If a review is required, a cytology fee is automatically incurred and charged to the patient. This fee of $60 will not be covered under Wellness coverage, **but will** fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance.

HUMAN PAPILLOMA VIRUS TESTING (HPV)

Human Papilloma Virus (HPV) is a common virus that affects both females and males. Most types are harmless, do not cause any symptoms, and resolve without treatment. Some are high risk and can cause cervical cancer or abnormal cells in the lining of the cervix that can sometimes turn into cancer.

If your pap smear shows atypical cells of undetermined significance (ASCUS), an HPV test for the High Risk subtypes may be ordered. If the results are negative, we will repeat your pap smear in one year. If the results are positive, we will call you into the office for additional testing.

HPV testing as a result of an abnormal pap smear will allow us to expedite testing and get results to you in a timely manner. There is an additional charge for HPV testing that is not covered under Wellness coverage, **but** will fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance. The charge is approximately $100 for HPV testing and will be billed to your insurance.

By signing below, you acknowledge receipt of the information regarding possible cytology fees and HPV test fees and you acknowledge that you and/or your insurance may be charged if medically necessary.

____
Patient Name (PRINT)

____ ______________________________
Patient Signature Date

____ ______________________________
Witness Date

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. YOU MAY ALSO FAX TO 601-936-1416 OR 601-936-3664.

For your convenience and compliance with medical legal requirements, East Lakeland OB-Gyn Associates provides our patients with On-line Patient Portal access. An invitation to the Portal will be sent to your email address that you provide us. Open the invitation and follow the link to complete the set up process. This will be your connection with your doctor and our staff to review test results, request prescription refills and ask questions concerning your care and health.

Thank you for choosing East Lakeland OB-Gyn Associates