



Marysville Obstetrics  
& Gynecology, Inc.

## New Patient History

### Completion Instructions

The following questionnaire is used to obtain as much pertinent medical information about you as possible, so all factors significant to your care will be identified. All information is confidential, so please provide answers as accurately as possible. Responses to questions that are non-applicable or unknown should be left blank. In other parts of the questionnaire, you should circle *yes* if appropriate, but circle nothing if the answer is *no*. Thank you.

### Personal Information

Reason for Visit \_\_\_\_\_

Date \_\_\_\_\_ Name \_\_\_\_\_

What is your date of birth? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

How many years of schooling have you completed? \_\_\_\_\_

Do you have any pets? \_\_\_\_\_ What kind? \_\_\_\_\_

### Medical History

Do you have any religious beliefs that preclude or mandate a certain type of medical therapy? If *yes*, please explain:  
\_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_

When was your last mammogram?

Do you have a history of any of the following (circle *Yes* if applicable):

Lung problems . . . . .	Yes	Diabetes . . . . .	Yes
Asthma . . . . .	Yes	Blood clot in lungs or legs. . . . .	Yes
Kidney problems. . . . .	Yes	High blood pressure. . . . .	Yes
Abnormal Pap smear. . . . .	Yes	Anemia. . . . .	Yes
Cancer. . . . .	Yes	Heart problems. . . . .	Yes
Breast lump or cyst. . . . .	Yes	Sexually transmitted disease . . . . .	Yes

Other: \_\_\_\_\_

\_\_\_\_\_

## Current Medications

Do you take any medications? . . . . . Yes

If yes, please list the names, dosage and times per day for each medication.

Medication Name	Dosage	Times per Day

Do you use recreational drugs (cocaine, marijuana, hashish or hard drugs)? . . . Yes

## Allergy

Are you allergic to any medications? . . . . . Yes

If yes, please list the medication(s) and describe the reaction you have to each.

Medication Name	Reaction Description

## Surgery

Have you ever had surgery? . . . . . Yes

If yes, please list the type of and reason for the surgery and the place the procedure was performed.

Type of Surgery/Year	Reason for Surgery	Place

## Hospitalization

Have you ever been hospitalized? . . . . . Yes

If yes, please list the hospital, the reason for admittance and the occurring year.

Hospital	Reason	Year

## Injury

Have you ever had any major injuries? . . . . . Yes

If yes, please list the injury and applicable date below.

Injury	Date

Have you ever had a blood transfusion? . . . . . Yes

If yes, please provide the date for which the procedure was performed.

<b>Date:</b>
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## Miscellaneous

*Please circle one response per question.*

How many cups of caffeinated beverages do you drink per day?

fewer than 3                      3-5                      6-10                      more than 10

How many packs of cigarettes do you smoke per day?

none                      less than half a pack                      more than half a pack

Do you drink alcohol?

never                      once or less per week                      3 or more times per week

## Family History

Please list any and all family members (excluding spouse) with the following disorders:

Heart disease _____	Diabetes _____
High blood pressure _____	Cancer _____
Birth Defects _____	Mental retardation _____
Cerebral palsy _____	Inherited diseases _____
Sickle cell disease _____	Thyroid disease _____
Epilepsy _____	Kidney abnormalities _____

## Obstetrical History

Pregnancy Number	1	2	3	4	5	6	7
What year was each baby born?							
How much did each baby weigh?							
What sex was each child (M or F)?							
Approximately how long was each labor (hrs.)?							
How many months pregnant were you with each delivery?							
C-section or vaginal delivery (C or V)?							

Have you had an abortion? . . . . . Yes

If yes, please provide the information below.

Year \_\_\_\_\_ number of weeks pregnant \_\_\_\_\_

Year \_\_\_\_\_ number of weeks pregnant \_\_\_\_\_

Have you had a miscarriage? . . . . . Yes

If yes, please provide the information below.

Year \_\_\_\_\_ number of weeks pregnant \_\_\_\_\_

Year \_\_\_\_\_ number of weeks pregnant \_\_\_\_\_