Patient Name/I.D. Number _____ Physician Name _____

Obstetrical Medical History (to be filled out by patient)

Personal Health History

Physician's Notes

1. Are you allergic to any medications? ❑ Yes ❑ No If yes, please list: _____

2. Please mark any condition that you have or have had in the past:

❑ Epilepsy	❑ Thyroid Disorder	❑ Asthma	❑ Hepatitis
❑ Heart Disease	❑ High Blood Pressure	❑ Diabetes	❑ Herpes
❑ Kidney Disease	❑ Recurrent Urinary Tract Infections	❑ Arthritis or Lupus	❑ Migraine Headaches
❑ Headaches			
❑ Blood Disease	❑ Frequent Infections	❑ Depression	❑ Bowel Disease

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

4. Please describe any health problems or symptoms that you are having at this time: _____

Exposures Affecting Health

1. Do you smoke cigarettes? ❑ Yes ❑ No
2. Do you own or come in contact with a cat? ❑ Yes ❑ No
3. Do you drink alcoholic beverages? ❑ Yes ❑ No
4. Have you taken any medications taken since your last period? ❑ Yes ❑ No
5. Do you use any "recreational" drugs (i.e. cocaine,marijuana, etc.)? ❑ Yes ❑ No
6. Do you have a history of blood transfusion? ❑ Yes ❑ No
   a. Do you or your sexual partner have a history of intravenous drug use? ❑ Yes ❑ No
   b. Have you or your sexual partner had other sexual partners in the past 5 years? ❑ Yes ❑ No
   c. Have you or your sexual partner had exposure to gay or bisexual males? ❑ Yes ❑ No
7. Please list any sources of chemical or radiation exposure that you encounter: _____
8. If you are on a restricted diet, please describe: _____

Gynecologic Health History

1. When and where was your last Pap Smear? _____
   a. Have you ever had an abnormal Pap Smear? ❑ Yes ❑ No
   b. If yes, when and where were you treated? _____
2. Have you ever had gonorrhea, chlamydia, herpes, or pelvic inflammatory disease? ❑ Yes ❑ No
3. What is your HIV status? _____
4. Have you ever used an IUD (intrauterine device) for contraception? ❑ Yes ❑ No
   If yes, please indicate when: _____
   Did you have any complications? ❑ Yes ❑ No
   If yes, please describe: _____
5. Do you have a history of infertility? ❑ Yes ❑ No
   If yes, please describe: _____
6. Please list any other concerns you have relative to your past health history. _____

Patient Signature _____ Print Name _____ Date _____