OBGYN SPECIALISTS OF TEXAS

Please complete the following: TODAY'S DATE: _____

Full Name: _____ Date of birth: _____ Age: _____

Reason for today's visit: _____ Are you a **new** or **established** patient (circle)

Medical Information:

Medical History: Diabetes, Hypertension, Thyroid Disease, Depression, Asthma or Other Conditions: _____
_____

List Current Medications: _____

Known allergies to medications: _____

Previous Surgeries: Have you undergone any surgeries or procedures? Please list

	Date	*Surgery*	*Complications*
1			
2			
3			

Gynecological History:
Date of Last Period: _____ No of days of bleeding: _____
Age periods started: _____ No of days in between cycles: _____
Are you currently experiencing any problems with your periods? _____

Last Pap smear: _____ Previous abnormal Pap smears: _____
Result: _____ Treatment for abnormal pap smears in the past: _____
Did you have any other gynecological procedures in the past: _____

Are you currently sexually active: _____ No of partners: _____
History of sexually transmitted infections: _____
Date of last mammogram: _____

Obstetric History:

No	*Date of Delivery*	*Birth Weight*	*Gender*	*Type of delivery*	*Place of Delivery*	*Complications*

Family History: List any medical problems
Father: _____ Mother: _____
Siblings: _____ Other: _____
Family history of cancer: _____

Social History:
What kind of work do you do? _____
Do you smoke: _____ No of cigarettes a day: _____
Do you drink alcohol: _____ Amount per day: _____
Use of recreational drugs: _____

Signature: _____