Women's Care™ FLORIDA
North Florida Ob-Gyn

Patient's Name_____ **DOB:** _____/_____/_____ **Date:** _____
Age:_____ **Race** _____ **Ethnicity**_____**Language**_____

Referred by: _____
Reason for this Appt_____

Primary Care Doctor: _____**Preferred Pharmacy: name/street/location**_____

Last Pap Smear / Date:	_____	Normal	_____	Abnormal	_____
Last Mammogram / Date:	_____	Normal	_____	Abnormal	_____
Last Bone Density / Date:	_____	Normal	_____	Abnormal	_____
Last Colonoscopy / Date:	_____	Normal	_____	Abnormal	_____

Family History: Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
Heart Disease		Birth Defect		**Cancer**	
High Blood Pressure		Blood Clots		Breast/Age	
High Cholesterol		Diabetes		Melanoma	
Stroke		Kidney Problems		Ovarian	
Depression / Suicide		Thyroid		Colon	
Alzheimer's / Dementia		Osteoporosis		Other	

Medical Allergies

Item	Reaction

Current Medication

Drug	Dose	How Often

Current Medication

Drug	Dose	How Often

Past Medical History: Have you ever had any of the following illnesses? Check all that apply.

- ¦ Heart Trouble
- ¦ Kidney / Bladder Problems
- ¦ High Blood Pressure
- ¦ Low Blood Pressure
- ¦ Hypothyroidism
- ¦ Hyperthyroidism
- ¦ Migraine Headaches
- ¦ Rectal Bleeding
- ¦ Stomach Trouble /Ulcer/ IBS
- ¦ Osteoporosis
- ¦ DES exposure
- ¦ Dysplasia / HPV
- ¦ Fibroids
- ¦ Pelvic Prolapse
- ¦ Depression
- ¦ Endometriosis
- ¦ Seizures
- ¦ Chronic Fatigue
- ¦ Anemia
- ¦ High Cholesterol
- ¦ Hepatitis
- ¦ Anxiety
- ¦ Varicose Veins
- ¦ Diabetes
- ¦ Blood Disorders
- ¦ Breast Problems / Nipple Discharge
- ¦ Hemorrhoids
- ¦ Anesthesia Problems
- ¦ Heart Murmur / MVP
- ¦ Polycystic ovarian syndrome
- ¦ Genital Herpes /Genital Warts
- ¦ Cancer (type) _____
- ¦ STD type_____
- ¦ Other _____

Social History: Use of alcohol¦ Never ☐Occasional ☐Moderate ☐Daily **Illegal Drugs**¦ Yes¦ No

Tobacco Use: ☐Never Smoked ☐Current Smoker ☐Former Smoker

Surgical History: (Including Hospitalizations)

of **Pregnancies** _____ **Miscarriages** _____**Abortions**_____

Date	Procedure

Date	Delivery Type	Sex	Lbs / Oz	Complications