North Florida OB GYN LLC

St. Vincent's III
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Jacksonville , FL Zip 32204
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(Please fill out all information to the best of your ability) **Date:**_____

Patient's Name:_____ **DOB:** _____/_____/_____ **Age:**_____ **Race:**_____

Referred by: _____ **Primary Care Physician:** _____

Reason for Appt:_____ **Pharmacy:**_____
(Local and Mail Order)

Allergy/Reaction:_____
(Please list anything you are allergic to and the reaction it causes.)

Medication & Dosage:_____

_____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No.

Y N Have you ever had a blood transfusion? **Y N** Are you willing to have a blood transfusion to save your life?

Y N Ever had an abnormal Pap Smear? If yes, treatment_____ Year:_____

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea
Y N Kidney/Bladder Problem	**Y N** Fibroids	**Y N** Blood Disorders	**Y N** Hepatitis
Y N High Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Low Blood Pressure	**Y N** Depression	**Y N** Hemorrhoids	**Y N** Genital Herpes
Y N Thyroid Problem	**Y N** Endometriosis	**Y N** Anesthesia Problems	**Y N** Genital Warts
Y N Rectal Bleeding	**Y N** Seizures	**Y N** Heart Murmur/MVP	**Y N** Syphilis
Y N Stomach Trouble	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome	
Y N Ulcer	**Y N** Anxiety	**Y N** Chlamydia	**Cancer:**_____

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy).

Date	Procedure

Pregnancy History: Please list all pregnancies (including ectopic/miscarriage/abortion).

Date	Delivery Type (vaginal/cesarean)	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease. Who?_____
Y N High Blood Pressure. Who:_____
Y N High Cholesterol. Who?_____
Y N Blood Disorder. Who?_____
Y N Diabetes. Who?_____
Y N Thyroid Disease. Who?_____

Other Significant Family History:_____

Social History

Use of alcohol: **Never/Daily/Moderate** Use of tobacco: **Y N** _____ packs per day Use of drugs: **Y N**
Hx of domestic violence: **Y N** Sexually active: **Y N** Birth control method:_____

Last Pap:_____ **Last Mammogram:**_____ **Last Bone Density:**_____ **Last Colonoscopy:**_____
date date date date