Women's Care FLORIDA
North Florida Ob-Gyn

ST VINCENT IV
2 Shircliff Way, Suite 600
Jacksonville, FL 32204
Phone: (904) 387-9577 Fax: (904) 387-9245

Patient's Name: _____ **DOB:** _____/ _____/ _____ **Date:** _____

Age: _____ **Race:** _____ **Referred by:** _____

Reason for this Appt: _____ **Current birth control method:** _____

Primary Care Physician: _____

Have you ever had an abnormal pap? ☐ yes ☐ no Date: ____/ ____/ _____ Treatment: _____

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

Cancer	
Breast/Age	☐ yes ☐ no Who/age?
Uterine	☐ yes ☐ no Who/age?
Melanoma	☐ yes ☐ no Who/age?
Ovarian	☐ yes ☐ no Who/age?
Colon	☐ yes ☐ no Who/age?
Other:	☐ yes ☐ no Who/age?

Allergies

Item	Reaction

Medication

Drug	Dose	How often

Mediation

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
☐ Thyroid Problems
☐ Depression
☐ IBS
☐ Cancer (Type) _____
☐ Osteoporosis
☐ Anemia
☐ Endometriosis
☐ Fibroids
☐ Pelvic Prolapse
☐ Polycystic Ovarian Syndrome
☐ Ulcer
☐ Breast Problems / Nipple Discharge
☐ Hemorrhoids
☐ Rectal Bleeding
☐ Heart Murmur / MVP
☐ Anxiety
☐ Stomach Trouble
☐ Other _____
☐ Diabetes
☐ Anesthesia Problems
☐ Antibiotics for Dental work
☐ Cholesterol
☐ Blood Disorders
☐ Seizures

STD type: ☐**Chlamydia** ☐**Gonorrhea** ☐**Hepatitis** ☐**Genital Warts** ☐**Genital Herpes** ☐**Syphilis** ☐**HPV**

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

Are you willing to have a blood transfusion in order to save your life? ☐ **Yes** ☐ **No**

Surgical History: (Including Hospitalizations)

Date	Procedure

Total Pregnancies _____ **Miscarriages** _____ **Abortions** _____

Date	Delivery Type	Sex	Lbs/Oz	Complications

Social History: **Use of Alcohol** ☐ Never ☐ Daily ☐ Moderate **Cigarettes** _____ packs per day **Drugs** ☐ Yes ☐ No