Women's Care FLORIDA
North Florida Ob-Gyn

St. Vincent's V
2 Shircliff Way, Suite 920
Jacksonville, FL 32204
Phone: (904) 387-1401 Fax: (904) 387-3820

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

Race: _____ **Referred by:** _____ **Last Period:** _____ **Age of Onset:** _____

Regular? ☐ Yes ☐ No **Cycle Length:** _____ **days (from start to start). Duration** _____ **days.**

Post Menopausal? ☐ Yes ☐ No **Current birth Control Method/ Name of Birth Control:** _____

Reason for this Appt.? _____

PCP: _____ **Preferred Pharmacy and Ph#:** _____

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

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, brother, sister, or children)

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

Allergies

Item	**Reaction**

Medication

Drug	**Dose**	**How Often**	**Drug**	**Dose**	**How Often**

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

☐ Heart Trouble
☐ Kidney / Bladder Problems
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Thyroid Problems
☐ Migraine Headaches
☐ IBS
☐ Ulcer
☐ Stomach Trouble
☐ Osteoporosis
☐ DES Exposure
☐ Rectal Bleeding
☐ Fibroids
☐ Pelvic Prolapse
☐ Depression
☐ Endometriosis
☐ Seizures
☐ Other _____
☐ Chronic Fatigue
☐ Anemia
☐ Cholesterol
☐ Hepatitis
☐ Anxiety
☐ Varicose Veins
☐ Diabetes
☐ Cancer (type)
☐ Breast Problems / Nipple Discharge
☐ Hemorrhoids
☐ Anesthesia Problems
☐ Heart Murmur / MVP
☐ Antibiotics for Dental Work
☐ Polycystic Ovarian Syndrome
☐ Blood Disorders

STD Type: ☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ 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**

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