Women's Care™ FLORIDA
North Florida Ob-Gyn

St. Augustine OB-GYN
301 Health Park Blvd., Suite 219
St. Augustine, FL 32086
Phone: (904) 819-9898 **Fax:** (904) 819-9594

(Please fill out all information to the best of your ability) **Date:** __________________

Patient's Name: ____________________________________ **Marital Status:** ________ **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.)

Medications & Dosages: ____

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(s):_______________

Y N Heart Trouble	**Y N** Osteoporosis	**Y N** Diabetes	**Y N** Gonorrhea/Chlamydia
Y N Kidney/Bladder Problems -or- Urinary Incontinence	**Y N** Fibroids	**Y N** Bleeding Disorders/Blood Clots	**Y N** Hepatitis
Y N **High** or **Low** Blood Pressure	**Y N** Pelvic Prolapse	**Y N** Breast Discharge/Problem	**Y N** HIV
Y N Migraine Headaches	**Y N** Depression/Anxiety	**Y N** Hemorrhoids	**Y N** 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 Ulcer	**Y N** Anemia	**Y N** Antibiotic for dental work	**Y N** HPV
Y N IBS	**Y N** High Cholesterol	**Y N** Polycystic Ovarian Syndrome (PCOS)	**Y N** Abnormal Mammo
Y N Infertility	**Y N** Anxiety	**Y N** Ovarian Cysts	**History of Cancer:**_____________

Mo/Yr	**ILLNESSES or OPERATIONS**	**Complications** YES or NO

Obstetrical History
Please list the number of:

Premature Births__________ Miscarriages______________

Abortions ___________ Times Pregnant ___________

Living Children_________________

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
Y N High Blood Pressure
Y N High Cholesterol
Y N Blood Disorder
Y N Diabetes
Y N Thyroid Disease

Other Significant Family History:____

Social History

Use of alcohol: **Never/Daily/Moderate**
Drug use: **Y N**
LMP: __________________________
Date

Tobacco Use: Have you ever smoked? Y N
Current Smoker: ______packs per day OR
Former Smoker: quit date___________.
Sexually active: **Y N** Birth control method:____

History of Domestic Violence: **Y N**

Last Pap: __________ **Last Mammogram:** __________ **Last Bone Density:** __________ **Last Colonoscopy:** __________
Date Date Date Date