MONADNOCK OB GYN ASSOCIATES, PA

Chart # ____________________

PLEASE ANSWER THE FOLLOWING AS WELL AS YOU CAN Chart Page# ____________________

NAME: ______________________________ Age: ________ DOB: ______________ Today's Date

Primary Care Physician ____________________ Referred by: ____________________ Preferred Pharmacy:

REASON FOR VISIT:

Use back of form if additional space needed

	NONE	IF YES, EXPLAIN
1. MEDICAL PROBLEMS PAST AND PRESENT:	☐	**1.** ____________________
2. ALL SURGERIES INCLUDE ANESTHESIA PROBLEMS	NONE ☐	**2.** ____________________
3. MEDICATIONS: INCLUDE OVER THE COUNTER VITS, HERBS	NONE ☐	3. ____________________
4. ALLERGIES TO MEDICINE OR LATEX	NONE ☐	4. ____________________

MENSTRUAL HISTORY: Age of first menses ____________ Interval (from day 1 of bleed to day 1 of next cycle)
# of days of flow______________ Severity of cramps (1-10, 10 being worst)________ Age reached menopause

Do you have:	Yes	No	IF YES, EXPLAIN
Problems with periods	☐	☐	
Bleeding since Menopause	☐	☐	
Vaginal Itch/Discharge	☐	☐	
Pain/Bleeding with Intercourse	☐	☐	____________________
Breast Lump/Nipple Discharge	☐	☐	
Problems with Urination	☐	☐	
Do you or your partner use Contraception?	☐	☐	____________________
Have you had Pelvic infections or STD's	☐	☐	____________________
Have you had any Abnormal paps	☐	☐	____________________

Last pap Normal Abnormal Year ________
Last mammogram Normal Abnormal Year ________

OBSTETRICAL: *(Please provide the number of...)*

Total Pregnancies ______ Miscarriages/Abortions ______ Live Births
Still Births (after 7 months) ______ Cesarean Sections ______ Living children

FAMILY HISTORY: (*Has anyone in your family had...)*

	Yes	No	Relative
Breast Cancer	☐	☐	____________
Ovarian Cancer	☐	☐	____________
Uterine Cancer	☐	☐	____________
Cervical Cancer	☐	☐	____________
Colon Cancer	☐	☐	____________
Other Cancer	☐	☐	____________
Genetic/Hereditary Disease	☐	☐	

	Yes	No	Relative
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Stroke	☐	☐	
High Cholesterol	☐	☐	
Osteoporosis	☐	☐	
Thyroid Disease	☐	☐	

SOCIAL:

	Yes	No	
Smoking	☐	☐	________ Packs/Day
Alcohol	☐	☐	________ Drinks/Week
Caffeine	☐	☐	________ Cups/Day
Recreational Drugs	☐	☐	
Violence in Home	☐	☐	
Seat Belt Use	☐	☐	

Occupation:
Marital Status: S M D W

OFFICE USE ONLY

Medical History Summary Completed/Updated

Initials:__________ Date:__________ Initials:__________ Date:__________ Initials:_ __________ Date:
Initials:__________ Date:__________ Initials:__________ Date:__________ Initials:__________ Date:
Initials:__________ Date:__________ Initials:__________ Date:__________ Initials:__________ Date: