Date: _____

NORTHERN
Obstetrics & Gynecology
a department of Northern Regional Hospital

Patient Name_____ Date of Birth_____

Past Medical History
Have you had any of the following illnesses?

	Yes	No
Other		
Abnormal Mammogram		
AIDS		
Airway Obstruct Chronic		
Anemia		
Angina Pectoris		
Anxiety Disorder, General		
Arthritis		
Asthma		
Bartholin's Gland Abscess		
Bleeding Tendency		
Cancer		
Colitis		
Diabetes		
Emphysema		
Gallbladder Disorder		
Gastric Ulcer		
Genital Herpes		
Genital Syphilis		
Goiter		

	Yes	No
Gonorrhea		
Gout		
Hay Fever		
Heart Disease		
Hepatitis		
Herpes Simplex		
Hypertension		
Migraine		
Myocardial Infarct (Heart Attack)		
Renal (Kidney) Disease		
Rheumatic Fever		
Rhinitis, Allergic		
STD Exposure		
Stroke		
Thyroid Disorder		
Tuberculosis (TB)		
Upper Respiratory Infection		
Urinary Tract Infection		

Past Surgical History
Have you had any of the following surgeries?

	Yes	No
Other		
Appendectomy		
Breast Surgery		
Breast Lumpectomy		
Breast Mastectomy		
Cholecystectomy		
Colonoscopy		
Cystoscopy		
D&C		
Diagnostic Laparoscopy		

	Yes	No
Ectopic Pregnancy		
Endometrial Ablation		
Exploratory Laparotomy		
Hip Replacement		
Hysterectomy		
Joint Replacement		
Knee Replacement		
Previous C-Section		
Removal of Ovary		
Tubal Ligation		

Please list any medications you are taking – prescription or over the counter.

_____
_____
_____

Are you allergic to any medications? _____
_____

Family History
Check if any blood relative has or has had any of the following:

	Yes	No		Yes	No
Other			Hay Fever		
AIDS			Heart Attack		
Anxiety			Hypertension		
Arthritis			Kidney Disease		
Asthma			Leukemia		
Bleeding Tendency			Migraine		
Cancer			Multiple Pregnancy (Twins, Triplets, Etc)		
Colitis			Myocardial Infarct (Heart Attack)		
Congenital Heart Problems			Rheumatic Heart Disease		
Diabetes			Seizures		
Emphysema			Stroke		
Epilepsy			Suicide		
Gastric Ulcer			Tuberculosis (TB)		
Goiter			Unspecified Psychiatric Problem		
Gout					

Please explain any history marked as other: _____
_____

Please add any other pertinent history: _____
_____
_____

List any history of genetic disorders: _____
_____

Do you have any previous pregnancies? List year and type of delivery: _____
_____
_____

Social History
Do you or have you ever smoked? _____

Do you use or have history of using any type of drugs? _____

Do you or have you ever consumed any alcoholic beverages? _____

Preferred language: _____

Date: _____

List any advanced directives (Living will, health care power of attorney, do not resuscitate)? _____
_____

Do you have any history of physical abuse/domestic violence? _____

Do you have any current physical abuse/domestic violence? _____