Atlas OB-GYN

Patient History Form

PATIENT NAME:		**Date of Birth:**
Allergies: Medication or Item (i.e. latex)	Reaction (Type & Severity)	Date of Onset:

CURRENT MEDICATIONS: (please list ALL medications, including vitamins and supplements) **:**

Name	Dose	Frequency

GYNECOLOGIC HISTORY: please check all that apply

- ☐ Date of last pap:_____
- ☐ STI/STD
- ☐ Last mammogram_____
- ☐ HPV Vaccine Type:_____
- ☐ Abnormal Pap
- ☐ Sexually Active
- ☐ Birth Control
- ☐ Last Period:_____
- ☐ Sexual Problems Type:_____
- ☐ Age at 1st period _____
- How long:_____
- ☐ Age at Menopause____

OBSTETRIC HISTORY: please include info on all pregnancies

Total pregnancies:____ Full Term:_____ Premature:_____ Abortions_____
Miscarriages:_____ Ectopics:_____ Multiples:_____ Living children_____

PAST PREGNANCIES: please include ALL info below

Delivery Date	Wks pregnant	Gender	Birth Weight	Hrs in labor	Anesthesia	Vaginal/ Cesarean	Complications:	Name

FAMILY HISTORY: (please check all that apply and indicate which family member/side of family):

- ☐ Breast Cancer Who:_____ Age:_____
- ☐ Ovarian Cancer Who:_____ Age:_____

☐	Colon Cancer	Who:_____	Age:_____
☐	Endometrial Cancer	Who:_____	Age:_____
☐	Diabetes	Who:_____	Age:_____
☐	High Blood Pressure	Who:_____	Age:_____
☐	Heart Disease	Who:_____	Age:_____
☐	Stroke	Who:_____	Age:_____
☐	Thyroid Disease	Who:_____	Age:_____
☐	Osteoporosis	Who:_____	Age:_____

SOCIAL HISTORY:

Your Occupation:_____

Marital Status: Single Married Divorced Widowed Partner

Name of Spouse (if applicable):_____ DOB:_____

Children's names (if applicable):_____

Check all that apply:

☐	Current smoker	If yes, how much:_____	Previous Smoker: Quit_____
☐	Drink Alcohol	If yes, what type:_____	How often:_____
☐	Drink Caffeine	If yes, what type:_____	How often:_____
☐	Use IV drugs	If yes, what type:_____	How often:_____
☐	Use Marijuana	If yes, how often:_____	Last used:_____
☐	History of Domestic Abuse	If yes, when_____	Currently safe:_____
☐	History of Sexual Abuse	If yes, when_____	

SURGICAL HISTORY: please list any surgeries you've had

Procedure	Reason	Year/Date

PAST MEDICAL HISTORY: (your personal history) Please check all that apply;

☐	Abuse	☐	Deep Vein Thrombosis	☐	Infertility
☐	Acid Reflux	☐	Depression/Postpartum	☐	Kidney/bladder problems
☐	Acne	☐	Diabetes	☐	Lung Disease
☐	Anemia	☐	Eating Disorder	☐	Neurologic/Epilepsy
☐	Anesthesia complications	☐	Endometriosis	☐	Osteoporosis
☐	Anxiety disorder	☐	GI problems	☐	Other: _____
☐	ART (IVF or FET)	☐	Gestational Diabetes	☐	Ovarian Cancer
☐	Arthritis	☐	Headaches	☐	PCOS
☐	Asthma	☐	Heart Problems	☐	Polyps
☐	Autoimmune disorder	☐	Hematologic dysfunction	☐	Preeclampsia
☐	Birth defects	☐	Hepatitis/Liver Disease	☐	Psychiatric disorder
☐	Blood transfusion	☐	High Cholesterol	☐	Pulmonary (TB, etc.)
☐	Breast Cancer	☐	History of STI/STD	☐	Stroke
☐	Breast problems	☐	History of abnormal pap	☐	Thyroid Disease
☐	Cancer	☐	Hypertension	☐	Trauma