OBGYN of Jacksonville
TopLine MD Alliance

MEDICAL HISTORY

Name: _____ Age: _____ Occupation: _____

Allergies/Reactions:	Height:
Current Medications:	

Pregnancy history: __# of pregnancies __# of live births __# of miscarriages __# of abortions __# of living children

Date	Cesarean Delivery	Vaginal Delivery	Birth Weight	Complications

Past Surgeries/Hospitalizations/Injuries:

Date	Procedure	Complications

Social History:

Use of tobacco: Never/Currrent/Past # cigs a day _____	Alcohol Use: Never/Daily/Social/Rare # of drinks per month _____	Drug Use in past 12 months: Y/N Type of drug _____	Domestic abuse: Y/N Past/Current Sexual abuse Y/N Past/Current

Past Patient Medical history (check all that apply)

	Cancer		Breast Disease		Stroke		Syphilis
	Diabetes		Kidney Disease		IBS		Gonorrhea
	Heart Disease		Eye Disease		Hepatitis A		Chlamydia
	High Blood Pressure		Depression		Hepatitis B		Herpes
	Epilepsy		Bipolar Disease		Hepatitis C		Fibroids
	Tuberculosis		Schizophrenia		PID		Endometriosis
	HIV/Aids		Other Mental Illness		Abnormal Pap		Cysts on ovary

Present Complaints:

Sexually Active: Yes ( ) No ( )	Date of last period: (1st day)
Pain with sexual intercourse: Yes ( ) No ( )	Date of last papsmear:
Irregular Periods: Yes ( ) No ( )	Where was it done:
Any Pelvic Pain: Always ( ) sometimes ( )	Any history of abnormal Pap: Yes ( ) No ( )
Vaginal Discharge ( ) Odor ( ) Itching ( )	Any History of STD?
Menopausal: Hot Flashes ( ) Sweats ( )	Breast: Lump ( ) Pain ( ) Discharge ( )
Mood swings ( )	Pregnant now? Weeks ( ) Days ( )
Pain with bleeding: Yes ( ) No ( )	Expected delivery date:
Urination: Discomfort ( ) Too often ( )	Bleeding this pregnancy? Yes ( ) No ( )
Do you leak urine on cough/sneeze ( )	Any ultrasounds done?
Bleeding: Normal ( ) Heavy ( ) Light ( )	Any pregnancy complications this pregnancy?
Other problems:	Transferring to us...Where did you get prenatal care this pregnancy?

Any family history of cancer? Y/N

Family member relationship _____ What type of cancer? _____