SOUTH LAKE OB/GYN & ADVANCED SURGERY
1900 DON WICKHAM DRIVE. SUITE 120 CLERMONT, FLORIDA 34711

MEDICAL HISTORY

Name: ____ Age: _________ Date: ______________
E-mail address: ____
Name of Primary Physician: _________________________________ Date last seen: ________________

Are you (or could you) be pregnant at this time? Yes No
Do you have a latex allergy? Yes No
Do you have an Advanced Directive (regarding medical care in case you are incapacitated?) Yes No

DRUG ALLERGIES:

1. _________________________ 2. ________________________ 3. _______________________

CURRENT MEDICATIONS: (list medications, dosages, & frequency)

1. ________________________ 2. ________________________ 3. ________________________
4. ________________________ 5. ________________________ 6. ________________________
7. ________________________ 8. ________________________ 9. ________________________

VITAMIN OR HERB SUPPLEMENTS: (list medications, dosages, & frequency)

1. ________________________ 2. ________________________ 3. ________________________
4. ________________________ 5. ________________________ 6. ________________________

VACCINATION HISTORY: (please circle all that apply)

Have you had all your childhood vaccines? Yes No **Tetanus in the past 10 years**? Yes No
Hepatitis B Vaccine? Yes No **Flu shot this year?** Yes No **Pneumococcal Vaccine?** Yes No

PREVENTATIVE MEDICINE HISTORY:

	Date of Last (if any)	(circle below)		Please explain abnormal results below
Last Pap	__________	Normal	Abnormal	_______________________________
Mammogram	__________	Normal	Abnormal	_______________________________
Bone Density Test	__________	Normal	Abnormal	_______________________________
Colonoscopy	__________	Normal	Abnormal	_______________________________
Barium Scan	__________	Normal	Abnormal	_______________________________
Stool test for blood	__________	Normal	Abnormal	_______________________________
Cholesterol Test	__________	Normal	Abnormal	_______________________________
Thyroid Test	__________	Normal	Abnormal	_______________________________

PAST OBSTETRICAL HISTORY: (indicate number)

Total times pregnant including miscarriages: ___ FULL term deliveries (37 weeks pregnant or beyond) ____
Pre-term deliveries (less than 37 weeks) ____Miscarriages and abortions ___ Number of living children ___

Pregnancy complications: NONE (please check all that apply)

Baby died near term: ____ Cord Prolapse: ____ Ectopic pregnancy: ____ 1st trimester bleeding: ____
Gestational Diabetes: ____ HELLP Syndrome: ____ Infertility: ____ Incompetent cervix: ____
Growth Retardation: ____ Placenta Abruption: ____ Placenta Previa: ____ Pre-Eclampsia: ____
Premature rupture of membranes at ______ weeks Pre-term labor at ______ weeks
Shoulder Dystocia: ____ Recurrent Miscarriages ____ Twins/Multiple babies: ____
Other: ____

MENSTRUAL: (please circle all that apply)

Age at first period? _____ **Date of last period?** _____ **Cycles are/were**? Regular Irregular

Menses flow? Light Moderate Heavy **Typically last _____ number of days**

Symptoms include: Bloating Breast tenderness Mood swings Abdominal pain/cramps Other: _______________

Do you have a history of any of the following? (please circle all that apply)

Abnormal pap smear/s	Adenomyosis	Breast disease	Chronic Pelvic Pain	Endometriosis
Fibroids	Exposure to DES	Urinary Incontinence	Ovarian Cyst	Pelvic Adhesions
Pelvic Inflammatory Disease	Polycystic Ovary	Uterine Prolapse	Cervical Cancer	Endometrial Cancer
Ovarian Cancer	Other: ____________	Please explain: ______________________________		

POSTMENOPAUSAL WOMEN ONLY: (please check all that apply)

Night Sweats _____ Hot flashes # _____ times per day Pain with Intercourse _____

Vaginal Dryness _____ Mood Liability _____ Bone Pain _____

Length of time experiencing these symptoms # _________ months/years (circle one) Other: ____________________

SEXUAL HISTORY: (please circle all that apply)

Birth control currently being used: NONE Condoms Diaphragm IUD Pills Injection Vasectomy Other: ____________

Sexual preference? Heterosexual Homosexual **Are you currently sexually active?** Yes No

 # lifetime sexual partners? More/Less than 5 **Age first had intercourse?** More/Less than 16 years old

Level of sexual interest? Healthy Decreased Absent

Have you ever been diagnosed with any of the following? (please check all that apply)

Chlamydia ___ Gonorrhea ____ Trichomonas ____ Syphillis ____ HIV ____ HPV/Genital Warts ____ Herpes ____

Please tell us the date and if you were treated: ____

PAST MEDICAL HISTORY: (please circle all that apply)

Alcoholism	Anemia	Asthma	Arthritis	Atrial Fibrill	Deep Vein Thrombosis
Bleeding Tendency	Crohn's/Colitiss	Colon Polyps	Depression	Diabetes	Heart Attack
Emphysema	Epilepsy	Glaucoma	Goiter	Hay Fever	High Blood Pressure
Hepatitis (B or C)	Heartburn	Heart Failure	Hyperthyroid	Hypothyroid	Mitral Value Prolapse
Kidney Disease	Leukemia	Liver Disease	Mental Illness	Migraine	Tuberculosis
Nervous Breakdown	Obesity	Pneumonia	Rheumatism	Stroke	Other Cancer: ________
Ulcers	Breast Cancer	Cervical Cancer	Colon Cancer	Ovarian Cancer	Other Condition: _______

FAMILY HISTORY: (please list disease for each member)

Paternal Grandmother: ______________________ Maternal Grandmother: ______________________

Paternal Grandfather:_______________________ Maternal Grandfather: ______________________

Father: ______________________________ __ Mother: ______________________________

Uncles: ______________________________ __ Aunts: ______________________________

Brothers: ____________________________ __ Sisters: ______________________________

PAST SURGICAL HISTORY: (please circle all that apply AND indicate the year it occurred)

Appendix	____	Breast Biopsy	____	Hernia	____	Kidney	____
Tonsils	____	Cervical Biopsy	____	D&C	____	Endometrial Biopsy	____
Hysterectomy	____	Hystosalpingogram	____	Tubal Ligation	____	Laparoscopy	____
Mastectomy	____	Ovary(ies) Rt or Lft	____	Other: ______________________			

PAST PROCEDURE HISTORY:

Test	**Body Region**	**Results**
Ultrasound of	______________________	______________________________
CT Scan of	______________________	______________________________
MRI of	______________________	______________________________

PERONAL INFORMATION:

Current Occupation: ______________________________ **Marital Status:** Married Single Divorced Widowed

Current aerobic exercise program? Yes No **How many days a week do you exercise?** ______

Alcohol use? Yes No **If yes, how many drinks per day?** _____

Have you ever smoked? Yes No **Do you smoke now?** Yes No **Packs per day?** ____ **How many years?** _____

Do you take any illicit street drugs? Yes No If yes, which? ____

Do you drink caffeinated products (soda, coffee, tea, energy drinks)? Yes No **If yes, how many cups per day?** _____

SYMPTOMS: (check symptoms you currently have)

General
- ___ Fever
- ___Chills
- ___ Appetite Change
- ___ Dehydration
- ___ Mental Status Changes
- ___Acute Diseases

Genital
- ___Pain
- ___ Masses/Growths
- ___ Abnormal Bleeding
- ___ Abnormal Discharge
- ___Pain w/Intercourse
- ___ Pain w/Menstrual Cycle
- ___ Rashes

Neurological
- ___ Seizures
- ___ Speech Changes
- ___ Loss of Sensation
- ___ Loss of Movement

Hematological
- ___ Easy Bruising
- ___ Bleeding Disorder
- ___ Clotting Disorder

Heart
- ___ High Blood Pressure
- ___ Palpitations
- ___ Chest Pain/Angina
- ___ Edema in Arms/Legs
- ___ Rapid Heartbeat
- ___ Irregular Heartbeat
- ___ High Cholesterol

Head, Eyes, Ears, Nose, Throat
- ___Head Injury
- ___Visual Changes
- ___ Eye Pain
- ___ Sinus Congestion/Drainage
- ___ Hearing Changes
- ___ Neck Mass
- ___ Neck Pain
- ___ Throat Drainage
- ___ Throat Pain
- ___ Oral Ulcers
- ___ Hoarseness

Integumentary/Skin
- ___ Rashes
- ___ Masses
- ___ Unusual Skin Lesions
- ___ Itching
- ___ Hives
- ___ Scars
- ___ Scars that won't heal

Immunologic
- ___Immunosuppressanion
- ___Severe Allergies

Urinary
- ___ Pain w/Urination
- ___ Blood in Urine
- ___ Frequent Nighttime Urination
- ___ Chronic UTIs
- ___ Incontinence

Lungs
- ___Labored Breathing
- ___Coughing up Blood
- ___ Productive Cough
- ___ Congestion

Gastrointestinal
- ___ Abdominal Pain
- ___ Abdominal Masses
- ___ Heartburn
- ___ Nausea
- ___ Vomiting
- ___ Diarrhea
- _Constipation
- ___Blood in Stool
- ___ Tarry Stool
- ___ Vomiting Blood
- ___ Changes in bowel habits
- ___ Bloating
- ___ Excess Hunger
- ___ Gas
- ___ Hemorrhoids
- ___ Polyps
- ___ Rectal Bleeding
- ___ Ulcers

Psychiatric
- ___Depression
- ___ Suicidal Intentions
- ___ Homicidal Intentions
- ___ Anxiety
- ___ Known Psychiatric Disorders

Breast
- ___ Rashes
- ___ Lumps
- ___ Tenderness
- ___ Skin Lesions
- ___ Dimpling
- ___ Nipple Changes
- ___ Nipple Discharge

Musculoskeletal
- ___ Muscle Aches
- ___ Weakness
- ___ Fatigue
- ___ Arthritis
- ___ Osteoporosis
- ___ Difficulty w/Balance
- ___ Recent Fracture(s)

Endocrine
- ___Diabetes
- ___ Temperature Change
- ___Weight Change
- ___ Hot Flashes

Other symptoms not listed: ____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature: ____ Date: ______________