



Laurel Ob-Gyn

A Tradition of Personal Care

Date: _____ Patient Name: _____

DOB: _____ Last menstrual period: _____

How did you hear about Laurel Ob-Gyn, P.A. _____

Are you under the care of any other physicians? If yes, give who and reason(s): _____

DO YOU HAVE ANY ALLERGIES?

Last Pap Smear? _____

Have you ever had an abnormal pap? YES/NO If yes, when and what kind of treatment was done?

Do you smoke: Yes/No, how much per day _____ Are you a former smoker? Yes/No

Do you use smokeless tobacco? Yes/No Do you drink alcohol? Yes/No, how much _____

Do you use street drugs? Yes/No Do you drink caffeine? Yes/No, how much _____

Do you exercise? Yes/No how much _____

How many **pregnancies** have you had *including* miscarriages, and terminations.

Month, Day, Year Vaginal or C-Section Birth weight Male/Female Complications?

Last mammogram _____ Last Bone Density _____

Last Colonoscopy _____ Flu Shot _____

Gardasil (HPV) Vaccine _____ Tetanus _____

Do you have any Medical Problems?

Diabetes _____ High Blood Pressure _____ High Cholesterol _____

Anxiety _____ Depression _____ Heart

disease _____

Thyroid Problems _____ Cancer _____

Asthma _____

Reflux _____ Blood Clot _____ Arthritis _____

Are you currently taking any medications? If yes, please list *including* any over-the-counter meds.

List any hospitalizations and surgeries including dates:

Family History: *Blood Relatives Only*, Please indicate Maternal (mom's side) or Paternal (dad's side)

Heart: _____ Cancer: _____

Thyroid: _____ Blood Clot: _____