Wooster OB-GYN

Registration and Medical History

Emily L. Benekos, M.D., FACOG
Kristi A. Nixon, M.D. FACOG
John M. Weeman, M.D., FACOG

Name:_____Date Today:_____
Last **First** Initial Maiden Name

Home Address:_____ Your Current Occupation:_____
Street City

Spouse Name And Occupation:_____ Your Family Doctor (if any):_____

Were you referred by another doctor for today's visit? □Yes □No **Home Phone**:_____
Work Phone:_____

Status: □ Married □ Single □ Divorced □ Separated □ Widowed **Date of Birth**:_____ **Your Age**:_____

1. Do you or have you ever had any of the following **symptoms, diagnosis, or procedures**?

	Yes	No		Yes	No		Yes	No
Crushing Chest Pain	□	□	Severe Back Pain	□	□	Extreme Forgetfulness	□	□
Irregular Heart Rhythm	□	□	Spina Bifida	□	□	Multiple Sclerosis	□	□
Cardiac Catheterization	□	□	Paralysis	□	□	Epilepsy or Seizures	□	□
Bypass Surgery	□	□	Arthritis	□	□	Deafness	□	□
Congestive Heart Failure	□	□	Frequent Wheezing	□	□	Hemophilia	□	□
Pacemaker	□	□	Emphysema	□	□	Von Wilebrand's	□	□
Other Heart Problems	□	□	Asthma	□	□	Venous blood clots	□	□
Diabetes	□	□	Depression	□	□	AIDS/ARC	□	□
High Blood Sugars	□	□	Attempted Suicide	□	□	Hepatitis or Jaundice	□	□
Cancer or leukemia	□	□	Other Mental Disorder	□	□	High Blood Pressure	□	□
Ulcerative Colitis	□	□	Anorexia or Bulimia	□	□	Stroke	□	□
Ulcers	□	□	Alcohol Dependency	□	□	Excessive scarring	□	□
Chron's Disease	□	□	Drug Dependency	□	□	Severe Anesthesia rxn.	□	□
Diverticulitis	□	□	Sexual Transmitted Dz.	□	□	Other _____		

2. **Reason for Today's Visit**:_____
(Please use back of page if not enough space for this and other questions)

3. **Prior Surgeries** and year performed:

4. **Current Medications** and Dosages:

5. **Birth Control** (Please check one or more):
   - □ None-Not trying to avoid pregnancy
   - □ Menopause
   - □ Birth Control Pills
   - □ Partner had Vasectomy
   - □ Prior Tubal or Hysterectomy
   - □ Natural Family Planning
   - □ Abstinent or Not Sexually Active

6. Please list all **serious medical illnesses** and dates (i.e. diabetes, liver/kidney disease, cancers, etc):

7. Please indicate the Number of:
   Term Pregnancies_____
   Preterm Pregnancies_____
   Miscarriages_____ Abortions_____

8. Has anyone in **your immediate family** (mother, father, sibling, grandparent, or child) ever had:
   - □ Breast Cancer □ Colon Cancer
   - □ Ovarian Cancer □ Heart Disease
   - □ Uterine Cancer □ Diabetes

9. Have you ever smoked? □Yes □No
   Do you smoke now? □Yes □No

   Year you quit smoking (if applies)_____
   If you smoke now, how many packs/day?_____

10. Last date of following **studies and results**:

	Date	Normal	Abnormal	Abnormal in Past
Pap Smear	_____	□	□	□
Mammogram	_____	□	□	□
Colonoscopy	_____	□	□	□
DEXA	_____	□	□	□

11. Drug **allergies** and type of reaction to each drug: